The Modern Hospital

DECEMBER 1950

Both sides of the doctor-hospital controversy • Fire safety routine • Checklist of supervisor's virtues • Hospitals and civil defense • How to solve nursing turnover • Ways to celebrate Christmas • Credits and collections • How to stop thieves

ANOTHER BUILDING ADOPTS SLOAN AS 100% REPLACEMENT

THE Andrews HOTEL
MINNEAPOLIS 1
4TH STREET AT HENNEPIN

October 4, 1950

Sloan Valve Company
4300 West Lake Street
Chicago 24, Illinois

Gentlemen:

The ANDREWS HOTEL is now 100% equipped with Sloan Flush Valves. Several years ago we tried your valves as replacements for valves that had worn out. Later we tried other makes and found that they were not as satisfactory, so we standardized on Sloan. Now we are very glad to be fully equipped with valves that give full satisfaction.

Yours very truly,

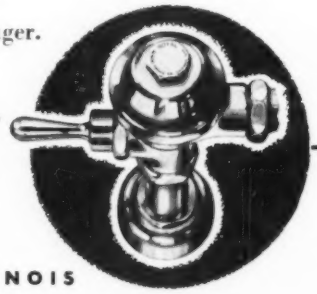
Leslie F. Long

Leslie F. Long, Manager

experience speaks again...

--"tried others--standardized on Sloan."

Each year the great number of new buildings in which SLOAN *Flush* VALVES are installed is an impressive confirmation of the Sloan reputation for complete satisfaction. Equally or even more impressive is the large number of *older* buildings in which, after adequate testing, Sloan Flush Valves have been installed as 100% replacement in preference to any other. Such records of leadership have significance for every building planner, contractor, owner and manager.



more **SLOAN** *Flush* **VALVES**
are sold than all other makes combined

SLOAN VALVE COMPANY • CHICAGO • ILLINOIS

Light weight, light color in a new type of Koroseal sheeting

Now there are seven types of Koroseal film and sheeting, a type to meet every hospital requirement. The latest addition to this recognized line is the Eggshell color, unsupported sheeting. It's available in 36", 45" and 54" widths.

This new type of sheeting combines light weight and light color . . . and gives you all the advantages of the Koroseal sheeting you regularly use in your hospital. That means long service life, dependable protection, greater comfort for patients, greater handling ease for nurses. This new sheeting will hold its color, withstand autoclaving, and it can be cleaned with ordinary soap and water or the regularly used cleaning agent. It does not retain odors. It resists gasoline, methyl and ethyl alcohol and ether. It is not affected by mineral acids or alkalies.

Include this new type sheeting in your next order for Koroseal sheetings and films. Use each type to meet the specific needs of your hospital. Koroseal films and sheetings give you better service, real economy. Insist on Koroseal when you order from your hospital supply house or surgical dealer. *The B.F.Goodrich Company, Sundries Division, Akron, Ohio.*

Koroseal — Trade Mark Reg. U. S. Pat. Off.

Koroseal Sheeting and Film BY

B.F.Goodrich

The Modern Hospital

PRESIDENT: OTHO F. BALL, M.D.

EDITOR: RAYMOND P. SLOAN

MANAGING EDITOR: ROBERT M. CUNNINGHAM JR.

TECHNICAL ADVISER: EVERETT W. JONES

ASSOCIATE EDITORS: MILDRED WHITCOMB, JANE BARTON

ADVERTISING DIRECTOR: J. W. CANNON JR.

DIRECTOR MARKET RESEARCH: RUSSELL T. SANFORD

PRODUCTION MANAGER: LEO KEDROK

DECEMBER 1950

ADMINISTRATION

Both Sides Could Be Wrong in the Doctor-Hospital Conflict ... 43
MARTHA O'MALLEY, M.D.

Speaking for the Medical Staff ... 44
FREDERICK T. HILL, M.D.

Three Views on State Hospital Superintendents ... 48

Fire Orders ... 49
CARL N. PLATOU

Good Supervision Is the Answer ... 51
EDMUND MOTTERSHEAD

Coal for the Poor ... 53

New Air for the Newborn ... 54

Hospitals *Versus* the Atom Bomb

I—Civil Defense ... 55
LT. COL. J. T. RICHARDS, M.S.C.

II—Architecture ... 58
ISADORE ROSENFIELD

Fog Room Gives Relief to Respiratory Patients ... 60

The High Cost of Nursing Turnover ... 61
NANCY CROWLEY FOWLER

Emotion in Gynecological Disorders ... 62

The Modern Hospital of the Month ... 63
CHARLES H. McCAULEY

Punch Card Accounting ... 66
FRANK R. BRADLEY, M.D., and WILLIAM ANDERSON

Christmas Comes to the Hospital

"Scrub Powder Art" Transforms Presbyterian ... 68
GEORGE W. WHARTON

Ward Decoration Contest at Milwaukee County ... 69
MRS. ELIZABETH S. KLETZSCH

Children's Party at Sheboygan ... 70
MRS. GERTRUDE OLSEN, R.N.

Stop Thieves by Setting Up Controls ... 71
KENATH HARTMAN

Credits and Collections ... 74
A MODERN HOSPITAL ROUND TABLE

John Howard ... 76
OTHO F. BALL, M.D.

Music With Their Meals Makes Patients Happy ... 77

Efficient Supply System ... 78
HAROLD E. FRYE
SMALL HOSPITAL FORUM

Modern Hospital Gold Medal Award ... 79

VOLUNTEER FORUM

Volunteers Contribute to the Christmas Spirit ... 82
ALMA M. TROXELL

Babies Alumni Association Raises Funds for Free Bed ... 84

MEDICINE AND PHARMACY

Gastric Cancer Tests ... 86
JOSEPH B. KELLY

Inapparent Salmonella Infections in Hospitals ... 92
JOSEPH FELSEN, M.D., ALFRED J. WEIL, M.D., and WILLIAM WOLARSKY, M.D.

Historical Aspects of Synthetic Drugs ... 98
NOTES and ABSTRACTS

FOOD AND FOOD SERVICE

Objectives of a Public Relations Program ... 104
E. ALLIENE MOSSO

Turkey on the Menu ... 105

Menus for January 1951 ... 110
BESSIE LOSIE

MAINTENANCE AND OPERATION

The Rôle of the Mechanical Engineer ... 112
GUY B. PANERO

Push-Button Laundry Equipment ... 118

HOUSEKEEPING

The Linen Closet Takes to Wheels ... 122
JOSEPH TURNER, M.D.

REGULAR FEATURES

We Introduce ... 4
Reader Opinion ... 6
Index of Advertisers ... Following Page 16
Small Hospital Questions ... 39
Looking Forward ... 41
About People ... 80
News Digest ... 128
Coming Meetings ... 144
Occupancy Chart ... 162
Want Advertisements ... 179
What's New for Hospitals ... 201
Volume Index ... Following Page 208

Published monthly and copyrighted, 1950. The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11, Ill. U. S. A. (Cable Address: Modital, Chicago.) Otho F. Ball, president; Raymond P. Sloan, vice president; Everett W. Jones, vice president; Stanley R. Clague, secretary; James G. Jarrett, treasurer. Subscription price: to hospitals and allied fields, architects, medical schools, libraries in North and South America, $3 a year; overseas, $5 a year. Single copies, 35 cents; back copies, 50 cents to $1. Subscriptions from all others, $8 a year; single copies, $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U. S. A. Eastern Office, 101 Park Avenue, New York 17, N. Y. Pacific Coast Representatives, McDonald-Thompson, Los Angeles, San Francisco, Seattle, Fort Worth, Portland, Denver.

AMONG THE AUTHORS

C. N. Platou

Carl N. Platou is serving his administrative residency at Northwestern Hospital, Minneapolis, where he was formerly an administrative assistant—a reversal of the usual order of events. A premedical student at the University of Minnesota before the war, Mr. Platou spent 12 months as a patient in various army hospitals. On his return to civilian life he switched his studies to social psychology and, after graduation, went to work at Northwestern Hospital. He continued doing part-time work at Northwestern while taking the university's graduate course in hospital administration, then stayed on at the hospital for his residency. To keep busy, he is studying accounting in the university's extension department. Mr. Platou's article on the fire safety program at Northwestern appears on page 49 of this issue.

Nancy Fowler

Nancy Fowler, whose article on "nursing turnover" appears in this magazine, is personnel director at Honolulu's Queens Hospital. A graduate of Radcliffe College, Mrs. Fowler took a year of graduate study in personnel management; she went to work for the General Electric Company at Schenectady, N.Y., then entered the hospital field as personnel director of the Boston Lying-In Hospital. She has been in Honolulu for the last two years.

G. P. Panero

Guy B. Panero, a mechanical engineering consultant, estimates that he has done mechanical engineering for some $150,000,000 worth of hospitals since the end of the war—including, among others, a V.A. hospital at Pittsburgh, Meadowbrook Hospital, Long Island, the James Ewing Hospital and Sloan-Kettering Institute in New York City, and the Greenwich Hospital at Greenwich, Conn. Mr. Panero studied engineering at Brooklyn Polytechnic Institute, Columbia University, and City College, New York. In addition to his hospital work, he has done a study for the defense department on the feasibility of underground construction. His article appears on page 112.

Dr. Joseph Felsen, whose article on Salmonella infections in the hospital appears on page 90 of this issue, is director of laboratories and research at the Bronx Hospital, New York City. Dr. Felsen is a graduate of Columbia University's College of Physicians and Surgeons; he is the author of several texts on intestinal infections. **Drs. William Wolarsky** and **Alfred Weil,** co-authors with Dr. Felsen of the study of Salmonella infections, are, respectively, epidemiologist and bacteriologist on the Bronx Hospital staff.

Joseph Felsen

William Wolarsky

Alfred Weil

Reader Opinion

Injection Costs

Sirs:

I have read with great interest the article "Medication Cost Study" in the September issue of The MODERN HOSPITAL. As the writer of the article has indicated, "labor saving devices have become an accepted part of the modern hospital." In this day and age of high labor costs, those of us whose duty it is to buy economically must be alert to new labor saving devices.

First of all, I must compliment the writer of the article and his associates on the careful research undertaken and accomplished to gather the necessary facts and data for the report. The tables published with the article are interesting and enlightening. I am assuming the authors' figures are correct as they were published.

The article compares the usage of the syringe and needle injection procedure with the newer disposable or so-called "automatic" type of injection. Table 1 covers "Cost of Syringe-Needle Method of Injection Exclusive of the Cost of Medication." Table 2 covers "Ward Cost of Automatic Method of Injection According to Type of Drug Replaced and Exclusive of the Cost of Medication." Table 3 covers "Average Time Required for the Complete Procedure of Injection Under the Two Methods."

The section headed "Investment Costs Calculated" states, "The total investment cost of syringes, needles, tubes for needles, and equipment necessary for the processing of needles and for the giving of injections on the wards was calculated for the syringe-needle method," and, *"the program permitted full study of every factor which might influence costs under both methods of injection."*

Further along in the article under "Facts of Syringe-Needle Method" it is stated, "The costs of making an injection were discovered to be, exclusive of ward and medication costs: $0.0168 investment cost per injection, $0.0221 syringe cost per injection, $0.0057 needle cost per injection, and $0.0212 central supply room cost per injection."

Under the heading "Facts of Automatic Unit Method" it is stated, "Because the unit is a sterile one discarded at the completion of each injection, few factors entered into the total cost. *The ward costs of preparing, giving and disposing of the unit were the only costs of significance;* the lower cost of using the mechanical unit can be related directly to the lower time factor. The number of seconds required to prepare, give and dispose of the automatic unit varied according to type of drug used; the decrease in time of preparation of an unquestionably sterile unit was noted as being of particular significance. The time of disposal was of such short duration that it was occasionally difficult to

time the busy nurse, and elimination of clean-up time reduced noticeably the work load of ward personnel."

Under the heading "Conclusions" the writer said "Time consumed in administering medication by means of the automatic disposable unit is certainly less than the comparable time of using a syringe and needle. On the basis of weighted averages, 72.4 seconds was saved per injection by using the automatic instead of the conventional method; almost two minutes of nursing time is saved per patient day by the use of the automatic disposable unit. If this is computed in the light of our high annual total of 239,121 days of patient care, it appears that we could have saved a total of 7213 nursing hours during 1949. *We appreciate that this saving is spread very thinly in actual practice*, but it does seems to indicate that the automatic disposable unit has particular advantage in situations where nursing time is at a premium and where conditions demand that either the prevailing procedures be streamlined or personnel be increased. *In computing and comparing costs of these two methods we must emphasize that the 'shelf cost' of the automatic unit naturally includes many of those items which we found to be part of the total injection cost of the syringe-needle method.* Consequently, if the comparative costs of these two methods as illustrated in tables 1 and 2 were computed on the basis of a full year's operation in our hospital, the use of the disposable unit would have saved some $26,090.49 in the case of multiple dose vial medications, where the cost differential is least, to some $36,710.24 in the case of tablet medication, where the saving is most apparent; *obviously, the medication costs cannot be adequately compared,* but where the 'injection cost' of using a syringe and needle is higher than the 'shelf cost,' the 'injection cost' warrants investigation. As the ratio narrows, it becomes more and more economical to use the mechanical unit, and the more expensive the drug, the greater is the saving."

Comments

1. *It has always been my experience that any cost study must include all of the materials, time and other costs involved. The only items which can be eliminated would be the identical ones.

2. This article does not include all of the necessary items involved in both cases. For instance: (a) In the syringe-needle method, everything entering into the cost is included except the cost of the drug or medication. (See table 1.) (b) In the disposable method, no cost is included except the cost of preparation, giving and disposal. No cost of either the medication or the apparatus used to administer it is given.

3. This is not a fair comparison of costs. We must compare the total cost of giving the medication, which must in this case include the medication and the apparatus used, whether it be the syringe and needle method or the newer disposable method.

4. As I see it, the only true comparison in table 1 and table 2 is item 5 of table 1 and the complete table 2. It is most obvious here that the cost of administering the disposable unit (high of $0.029 for penicillin in oil) is much lower than the syringe and needle method (high of $0.066 for tablet). The syringe and needle method costs over twice as much as the disposable unit—in *time expended for administering.*

But here the comparison ends. The impression is left with the reader after reading the "Conclusion" that here is a spot where real savings can be made.

Just the reverse is true in my estimation.

Below is printed the latest price list I have of a certain type of disposable units available.

Intramuscular Units	*Pkg. of*	*List*
Aqueous Susp. Procaine Penicillin	1	$1.30
Crystalline Procain Penicillin G 1 cc. (300,000 units per cc.) in Peanut Oil suspended with Aluminum Monostearate 2%	1	1.30
Procaine Penicillin G Fortified in Oil 1 cc. (400,000 units per cc.) 300,000 units Procaine and 100,000 units Potassium per cc. in Peanut Oil suspended with Aluminum Monostearate 2%	5	6.25
	1	1.55
	5	7.50
Subcutaneous Units		
Caffeine Sodium Benzoate 0.25 gm. (3¾ Gr.), 1 cc.	5	2.88
Caffeine Sodium Benzoate, 0.5 gm. (7½ Gr.), 1½ cc.	5	3.28
Codeine Phosphate 30 mg. (½ Gr.), 1 cc.	5	3.00
Codeine Phosphate 65 mg. (1 Gr.), 1 cc.	5	3.32
Ephedrine Sulfate 25 mg. (⅜ Gr.), 1 cc.	5	2.60
Ephedrine Sulfate 50 mg. (¾ Gr.), 1 cc.	5	2.72
Epinephrine Hydrochloride 1:1000, ½ cc., U.S.P. Sterile	5	2.60
Epinephrine Hydrochloride 1:1000, 1 cc., U.S.P. Sterile	5	2.60
Methadone Hydrochloride 5 mg., 1 cc.	5	2.72
Methadone Hydrochloride 10 mg., 1 cc.	5	3.00
Methadone Hydrochloride 15 mg., 1 cc.	5	3.28
Morphine Sulfate 10 mg. (1/6 Gr.) 1 cc.	5	2.60
Morphine Sulfate 15 mg. (¼ Gr.), 1 cc.	5	2.60
Morphine Sulfate 30 mg. (½ Gr.), 1 cc.	5	2.72
Morphine Sulfate, 15 mg. (¼ Gr.) and Atropine Sulfate, 0.4 mg. (1/150 Gr.) 1 cc.	5	2.72
Nikethamide 25%, 1½ cc.	5	3.32

Actual cost to a hospital of the size mentioned in the list would be about 50 per cent of these prices according to standard discounts usually available.

In column 2 of table 1 is indicated the highest labor cost for using tablet form of medication ($0.1318) by the syringe-needle method.

In column 4 of table 2 are shown the highest costs for administering the disposable unit (penicillin in oil) $0.0293.

Let us take item one from the list above of the disposable units. This 1 cc. vial of 300,000 units of penicillin per cc. lists at $1.30 less 50 per cent would make this cost $0.65 each. Add to this the cost of administering according to table 2 ($0.029) makes this cost total $0.679 per injection.

Now let us take the highest basic cost of injections from table 1 (syringe and needle), column 2 for tablets. This is $0.1318 per injection. Add to this the cost of 1 cc. of procaine penicillin containing 300,000 units per cc. Our cost at the hospital I represent is $0.23 per 1 cc. We buy the 10 cc. vial containing 3,000,000 units. Add these two costs together and you get a total of $0.3618 per injection.

Now comparing the two total prices for injecting penicillin, $0.679 each for the disposable unit and $0.3618 each for the injection by syringe and needle, we find an entirely different story. The disposable unit costs nearly twice (actually $0.3172 more) what the old syringe and needle method does. This figure is arrived at by using the figures in the published article plus the regular published prices for penicillin, or the disposable unit as the case may be.

Carrying this still farther and referring again to actual figures used, the article states that an average of 327,770 injections is made per year in a 728 bed hospital. This size hospital compares with the one with which I am connected. If we say that one-third of this total number of injections is for penicillin injections (and I am sure this percentage is low), approximately 110,000 injections per year would be for penicillin. (We do not keep a record of our quantities of injections, but one large and reputable hospital, which does keep records, has told me that penicillin injections total virtually 50 per cent of all injections given.) Multiply this (110,000 injections) by the saving of $0.3172 per injection by the syringe and needle method and we arrive at a total of $34,892 saved on the yearly injection of penicillin alone. The saving of about $0.03 per injection in time saved by the disposable unit looks rather insignificant in the face of this saving of money using the syringe and needle method.

In addition to this, similar savings would be made, I am sure, on all of the other items shown on the list of disposables available.

As is stated very aptly in the article, that by use of disposables, "This time saving is spread very thinly in actual practice but it does seem to indicate that the automatic disposable unit has particular advantage where nursing time is at a premium."

It is too thinly spread, in my estimation, to make it practical from the standpoint of cost to the hospital.

Warren W. Irwin
General Purchasing Agent
University of Rochester
Rochester, Minn.

What to look for in HOSPITAL CABINET CONSTRUCTION

Note these "Blickman-Built" features:

A — The one-piece top and splashbacks are seamlessly welded and coved where joined. All corners and intersections are fully rounded to eliminate dirt pockets.

B — The crevice-free seamless top is a smooth, continuous surface with all corners welded and joints eliminated.

C — The top is sound-deadened by a sub-plate of No. 14 gauge (.078") furniture steel.

D — The raised edges prevent spilling of liquids. The inverted "V"-edge front is integral with top and end.

E — All vertical and horizontal corners of sink are fully rounded and intersections of corners are spherically coved.

F — Sinks are seamlessly welded to top so that there are no dirt-catching crevices.

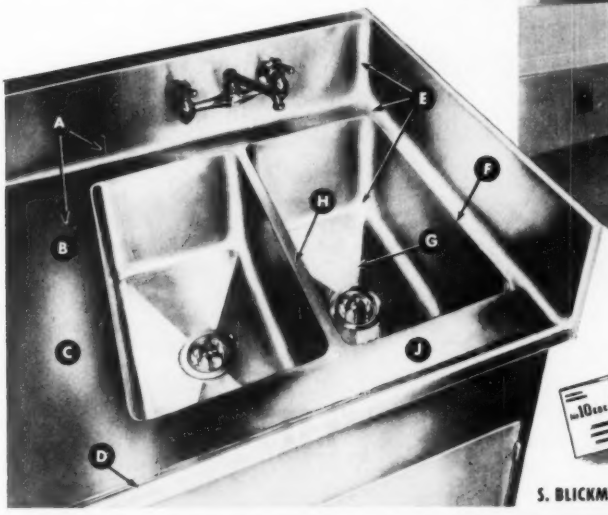
G — The bottom of sink drains completely, because it is scored and pitched to outlet.

H — The sink partition is double-walled and made of one sheet of metal, rounded at top and integrally welded.

J — Stainless steel of heavy gauge (never lighter than No. 14, .078") is polished to No. 4 mill finish, rather than having just a "grind" finish.

Stainless steel sinks and work tops should be of all-welded, round-corner construction

• When your cabinets require sinks or work tops, be sure they are made of heavy-gauge stainless steel in all-welded, seamless construction. This assures cleanliness, strength and durability and practically eliminates maintenance and replacement costs. Rounded corners and coved intersections simplify the task of cleaning. The stainless steel surfaces are permanently bright and attractive. See the column at the left for other important features. When these units are built to "Blickman" specifications, you are assured of hospital cabinets and case work that will give years of efficient service.

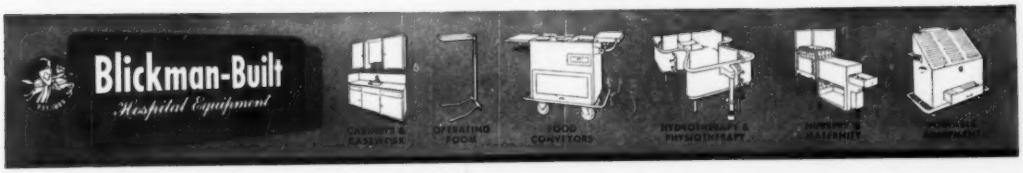


Blickman-Built stainless steel cabinets and work counter at St. Peters Hospital, Albany, N. Y.

Blickman-Built cabinets and case work are made of stainless steel as well as enameled steel. Recessed and free-standing units built to specifications. Layout and engineering service.

SEND FOR BULLETIN No. 10 CBC which describes and illustrates all types of Blickman-Built cabinets and case work for every hospital department . . . Send also for the May issue of "Trends," carrying a feature story about Blickman-Built cabinets.

S. BLICKMAN, INC. • 1512 Gregory Ave. • Weehawken, N. J.



ACTHAR, Armour Laboratories Brand of Adrenocorticotropic Hormone (A. C. T. H.), is no longer restricted to hospitalized patients, nor is special confirmation from the physician relating to its use required. ACTHAR now can be dispensed by or on the prescription of a physician and must be supplied in the original unbroken package.

✔ ACTHAR is preferred for its physiologic mode of action. ACTHAR stimulates the adrenal gland to secrete the whole spectrum of adrenal corticoids without inducing adrenal atrophy . . . a potential risk in substitution therapy.

Periodic Status Reports on ACTHAR therapy will be released by Armour Laboratories in order to keep the physician informed of the rapid developments in this important field of therapeutics.

ACTHAR is supplied in 10, 15, 25, 40 and 50 mg. vials, in packages of 10, 25 and 50 vials.

ARMOUR *Laboratories*

CHICAGO 11, ILLINOIS

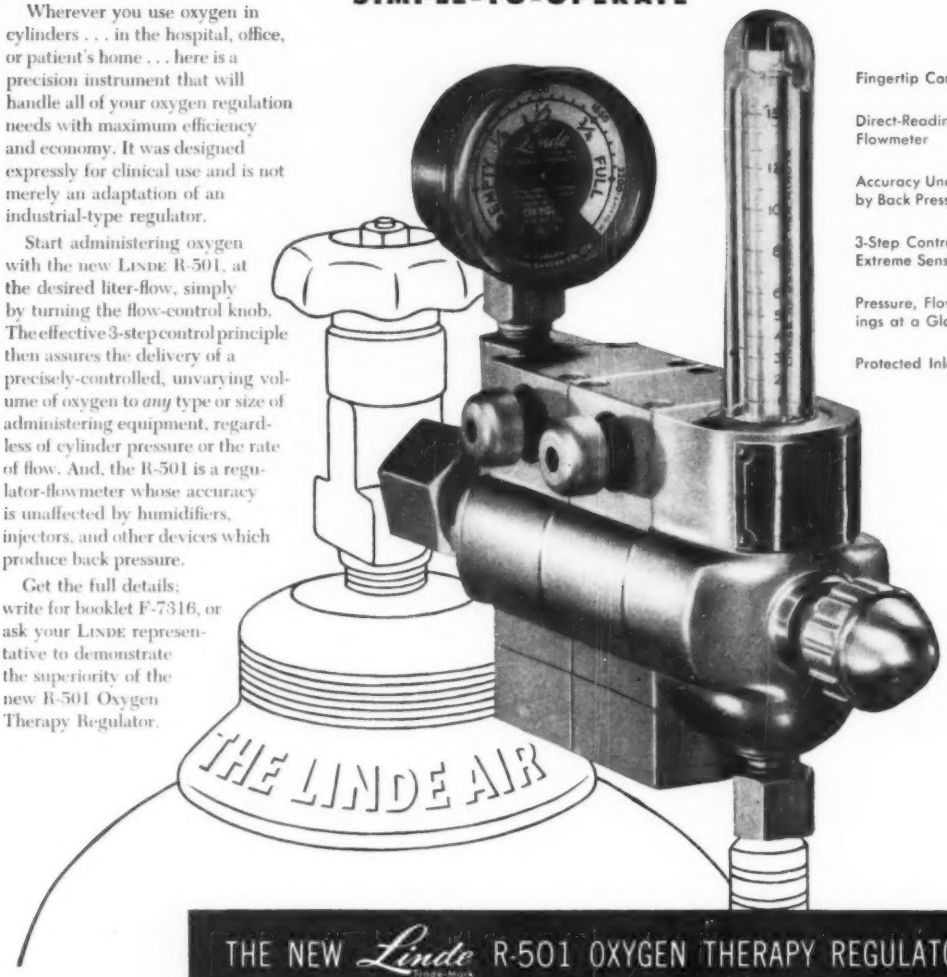
NOW... *a truly clinical regulator for Oxygen Therapy*

DEPENDABLE
ACCURATE
SIMPLE-TO-OPERATE

Wherever you use oxygen in cylinders . . . in the hospital, office, or patient's home . . . here is a precision instrument that will handle all of your oxygen regulation needs with maximum efficiency and economy. It was designed expressly for clinical use and is not merely an adaptation of an industrial-type regulator.

Start administering oxygen with the new LINDE R-501, at the desired liter-flow, simply by turning the flow-control knob. The effective 3-step control principle then assures the delivery of a precisely-controlled, unvarying volume of oxygen to *any* type or size of administering equipment, regardless of cylinder pressure or the rate of flow. And, the R-501 is a regulator-flowmeter whose accuracy is unaffected by humidifiers, injectors, and other devices which produce back pressure.

Get the full details; write for booklet F-7316, or ask your LINDE representative to demonstrate the superiority of the new R-501 Oxygen Therapy Regulator.



- Fingertip Control
- Direct-Reading Flowmeter
- Accuracy Unaffected by Back Pressure
- 3-Step Control for Extreme Sensitivity
- Pressure, Flow Readings at a Glance
- Protected Inlet

THE NEW *Linde* R-501 OXYGEN THERAPY REGULATOR

THE LINDE AIR PRODUCTS COMPANY
Unit of Union Carbide and Carbon Corporation
General Office: New York UCC Offices in Principal Cities
In Canada: Dominion Oxygen Company, Limited, Toronto

The term "Linde" is a registered trade-mark of The Linde Air Products Company.

Adlake aluminum windows are ideally suited to curtain wall construction

Although designed for a lifetime of service in *any* building, modern or traditional, Adlake Aluminum Windows are a "natural" for curtain wall installations. Built of lightweight aluminum, they do away with the cost of painting and maintenance, and keep their smart good looks and finger-tip control for the life of the building!

What's more, only Adlake Windows combine woven-pile weather stripping and serrated guides to assure minimum air infiltration. Adlake Windows never warp, swell, rot, rattle or stick, and installation is amazingly simple: *you can complete all exterior work first and then simply set the window in place!*

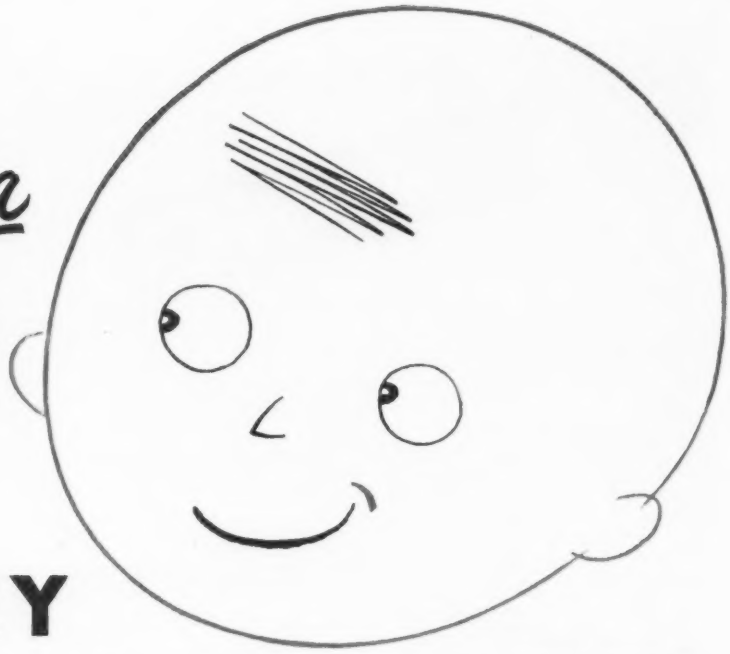
For complete information, please drop us a card today. Address The Adams & Westlake Company, 1105 N. Michigan, Elkhart, Indiana. No obligation, of course.

QUALITY APPROVED
DH-A1

THE Adams & Westlake COMPANY — Adlake TRADE MARK

Established 1857 • ELKHART, INDIANA • New York • Chicago

Like a Smile



IVORY

COSTS SO LITTLE • • GIVES SO MUCH!

IT isn't a case of "Can we afford it?" when you're considering the purchase of Ivory Soap. Rather, it's a matter of "Can we afford *not* to buy Ivory?" For no other soap is so thoroughly qualified to meet exacting hospital needs.

Ivory is superbly pure and mild. Its rich lather cleanses the skin gently and thoroughly. It has no strong perfume. It is equally pleasing for patient use and for hospital personnel. *And Ivory costs surprisingly little for a soap of such recognized fineness.*

Ivory Soap is available for hospital use in the popular unwrapped 3-ounce size, as well as in smaller sizes—wrapped or unwrapped.

No other soap can give you more honest value for your soap dollars. This fact is confirmed by the many, many fine hospitals which have consistently used Ivory during the past half century.

Procter & Gamble
CINCINNATI, OHIO

99 44/100% pure--it floats

MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER!

REPRODUCED FROM THE PAINTING BY DAVENPORT

COURTESY, KENTUCKY STATE MEDICAL ASSOCIATION

Ephraim McDowell

1771-1830

On December 13, 1809, Dr. Ephraim McDowell performed the operation in Danville, Ky., which earned him the title "The Father of Ovariotomy," when he removed fifteen pounds of ovarian tumor from a woman patient. The first operation of its kind was performed at his home while horrified, enraged citizens surrounded the house, prepared to hang the doctor. However, the townspeople who came to kill remained to cheer; his patient lived to be 80, and Dr. McDowell became world-famous for his surgical skill and pioneer courage.

Ephraim McDowell was born in Rockbridge County, Va., November 11, 1771. He attended a classical school at Georgetown, Va.; studied medicine under Dr. Humphreys, of Staunton, Va., and at the University of Edinburgh, Scotland, in 1793 and 1794. In 1795 he started to practice medicine and surgery in Danville.

Dr. McDowell was elected a member of the Medical Society of Philadelphia in 1817; was one of the founders and an original trustee of Center College, Danville, Ky., 1819-1823. He died in Danville on June 20, 1830. A marble monument was erected to his memory in McDowell Park, Danville, by the State medical society, in 1879, and in 1929 he was further honored by his native state when his statue was unveiled in Statuary Hall, United States Capitol, Washington, D. C., presented by the State of Kentucky.

From the Series, Great American Surgeons, Published by Ethicon Suture Laboratories, Inc., New Brunswick, N. J.

The Surgiset for your office

SKIN CLOSURE SUTURES

Complete Emergency Suture Assortment
IN STERILE PACK JARS, READY TO USE

You don't waste time boiling tubes when you have the Surgiset. The germicide in the jars keeps tubes sterile.

Surgiset contains 3 dozen Atraloc eyeless needle sutures: 5-0 monofilament nylon on small cutting needle for facial repair; 3-0 dermal on medium cutting needle for normal skin repair; 2-0 dermal on heavy cutting needle for heavy skin.

Surgiset contains an extra jar for storing your other sutures.

Supplied complete with chrome-plated rack for the regular price of 3 dozen emergency sutures. (Jars and rack given without charge.)

ORDER FROM YOUR SURGICAL DEALER—CODE, EK 3

ETHICON SUTURE LABORATORIES

INCORPORATED

Suture Laboratories at New Brunswick, N. J.; Chicago, Ill.; Sao Paulo, Brazil; Sydney, Australia. In Scotland: Ethicon Suture Laboratories, Ltd., Edinburgh.

INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—28th Edition

A

Abbott Laboratories 170
Adams & Westlake Company (HPF) 15
Airkem, Inc. 156
Air Transport Assn. for Air Express Division, Railway Express 154
Alconox, Inc. 134
Alley Company, Inc., E. E. 142
Aloe Company, A. S. (HPF) 135
Amcoin Corporation 195
American Appraisal Company 191
American Cyanamid Company 155
American Floor Surfacing Machine Company 138
American Gas Association 167
American Hospital Supply Corp. (HPF) ..... 5, following page 32
American Laundry Machinery Co. (HPF) 35
American Standard Mfg. Company 193
American Sterilizer Company (HPF) 9
Anchor Brush Company 181
Applegate Chemical Company (HPF) 198
Armour Laboratories 12, 13
Armstrong Company, The Gordon (HPF) ..facing page 41
Armstrong Cork Company 115
Aseptic-Thermo Indicator Company 88
Atlantic Alloy Industries, Inc. 20

B

Barnstead Still & Sterilizer Co. (HPF) 137
Baxter Laboratories ..... following page 32
Birtcher Corporation (HPF) 195
Bishop & Company Platinum Works, J. (HPF) 168
Blair Aluminum Furniture Co. 34
Blank & Company, Inc., Frederic (HPF) 123
Blickman, Inc., S. (HPF) 11, 109
Brillo Manufacturing Company 174

C

Carolina Absorbent Cotton Company ..... following page 160
Cash, Inc., J. & J. (HPF) 174
Castle Company, Wilmot (HPF) 131
Ceco Steel Products Corp. 18
Chamberlin Company of America (HPF) 193
Clark Linen & Equipment Co. 168
Clarke Sanding Machine Company (HPF) 19
Classified Advertisements 179-196
Clay-Adams Company, Inc. 36, 37
Colgate-Palmolive-Peet, Inc. 145
Commercial Solvents Corp. 83
Congoleum-Nairn, Inc. 164
Continental Coffee Company 107
Continental Hospital Service, Inc. (HPF) 147
Corning Glass Works 90
Crane Company (HPF) 141
Cutter Laboratories (HPF) 174

D

Darnell Corporation Ltd. (HPF) 146
Davis & Geck, Inc. (HPF) 27
Deco-Plastics, Inc. ..... following page 144
Deknatel & Son, Inc., J. A. 194
DePuy Manufacturing Company (HPF) 180
Detroit-Michigan Stove Company 31
Detroit Steel Products Company 133
Diack Controls (HPF) 130
Dixie Cup Company 30
Don & Company, Edward 196
Dundee Mills, Inc. 200

E

E & J Manufacturing Company (HPF) 153
Eastman Kodak Company 93
Edwards Company, Inc. 166
Eichenlaubs 189
Emerson Company, J. H. (HPF) 144
Ethicon Suture Laboratories (HPF) ..... following page 16

F

Fairbanks, Morse & Company 195
Fairchild Camera & Instrument Corp. (HPF) 160
Finnell System, Inc. (HPF) 187
Flex-Straw Corporation 150
Flynn Manufacturing Company, Michael 113
Foley-Irish Corporation 183
Fostoria Pressed Steel Corp. 186
Frick Company 188

G

General Electric X-Ray Corporation (HPF) 24
General Foods Corporation 185
Gennett & Sons, Inc. (HPF) 190
Gerson-Stewart Company 96
Glasco Products Company 171
Globe Automatic Sprinkler Co., Inc. 195
Goder Incinerators, Joseph 168
Goodall Fabrics, Inc. 175
Goodrich Company, B. F. 1
Gray Manufacturing Company (HPF) 169
Gumpert Company, Inc., S. (HPF) ..... 4th cover

H

Hall & Sons, Frank A. (HPF) 197
Hall China Company ..... 3rd cover
Haney & Associates, Inc., Charles A. (HPF) 199
Hard Manufacturing Company (HPF) 165
Hauserman Company, The E. F. 125
Hausted Manufacturing Company 184
Herrick Refrigerator Company (HPF) 196
Heyden Chemical Corporation 97
Hild Floor Machine Company (HPF) 142
Hill-Rom Company (HPF) 183
Hillyard Sales Companies (HPF) 189
Hobart Manufacturing Company ..... facing page 105
Hoffmann-LaRoche, Inc. 89
Hood Rubber Company 25
Hospital Purchasing File 126, 127

Hotpoint, Inc. (HPF) 111
Hunter Douglas Corporation (HPF) 163
Huntington Laboratories, Inc. (HPF) ..... facing page 145

I

Imperial Paper & Color Corporation 119
Institutional Products Corporation 91
Insurance Company of North America Companies 189
International Nickel Company, Inc. 23

J

Johnson & Company, A. 199
Johnson & Johnson 81
Just Manufacturing Company 182

K

Kelley-Koett Mfg. Company (HPF) 129
Kenwood Mills (HPF) 197
Ketchum, Incorporated (HPF) 176
Kohler Company 116

L

Landers, Frary & Clark 151
Lawson Associates, Inc., B. H. (HPF) 158
Leonard Valve Company (HPF) 191
Libbey-Owens-Ford Glass Company 117
Lilly & Company, Eli 3
Linde Air Products Company, The Unit of Union Carbide & Carbon Corporation 14
Liquid Carbonic Corporation (HPF) 136

M

McCray Refrigerator Company (HPF) 143
McGuire-Johnson & Associates 197
Macalaster Bicknell Company (HPF) 95
Mallinckrodt Chemical Works 101
Marvin-Neitzel Corporation 8
Meese, Inc. 190
Mercer Glass Works 174
Miller Rubber Sundries Division 1
Minneapolis-Honeywell Regulator Co. (HPF) 121
Moore, Inc., P. O. 199

N

National Cash Register Company (HPF) 157
National Cylinder Gas Company (HPF) 21
Nestle Company, Inc. 192
New Castle Products, Inc. 181
Nuclear Instrument & Chemical Corporation 152

O

Oakite Products, Inc. 10
Orthopedic Frame Company (HPF) 198

P

Parke, Davis & Company 87
Permutit Company 140
Pfizer & Company, Inc., Charles 173
Philmont Manufacturing Company 168
Photostat Corporation 17
Pick Company, Inc., Albert 148
Pioneer Rubber Company (HPF) 38
Pittsburgh Plate Glass Company ..... following page 112
Polar Ware Company (HPF) 159
Potter Mfg. Corporation 199
Powers Regulator Company 139
Precision Scientific Company 102
Procter & Gamble 16
Prometheus Electric Corporation (HPF) 28
Puritan Compressed Gas Corp. 6

Q

Quicap Company, Inc. 186

R

Republic Steel Corporation 40
Rixson Company, Oscar C. (HPF) 120
Robertson Company, H. H. 124
Ross, Inc., Will 172
Russell Company, F. C. 185

S

Scott Aviation Corporation (HPF) 184
Seamless Rubber Company (HPF) 7
Seven Up Company 149
Sexton & Company, John ..... following page 104
Shampaine Company (HPF) 22
Simmons Company (HPF) ..... following page 128
Sloan Valve Company ..... 2nd cover
Smith & Underwood 130
Smooth Ceilings System (HPF) 148
Struthers Wells Corporation 132

T

Tile-Tex Division (HPF) ..... following page 40
Torrington Company 187

U

Union Carbide and Carbon Corporation, The Linde Air Products Company Unit 14
United Fruit Company 29
U. S. Hoffman Machinery Corporation (HPF) ..... facing page 113
U. S. Plywood Corporation (HPF) ..... facing page 144, 177
Utica & Mohawk Cotton Mills, Inc. 178

V

Vestal, Inc. (HPF) 32
Vollrath Company (HPF) 161

W

Wander Company 33
Weck & Company, Inc., Edward (HPF) 103
Westinghouse Electric Corp. 85
White Mop Wringer Company 191
Wilmot Castle Company (HPF) 131
Winthrop-Stearns, Inc. 26, 99
Witte Engine Works 162

HOSPITALS

can save time and money with

PHOTOSTAT

REG. U. S. PAT. OFF.

Photographic Copying Equipment

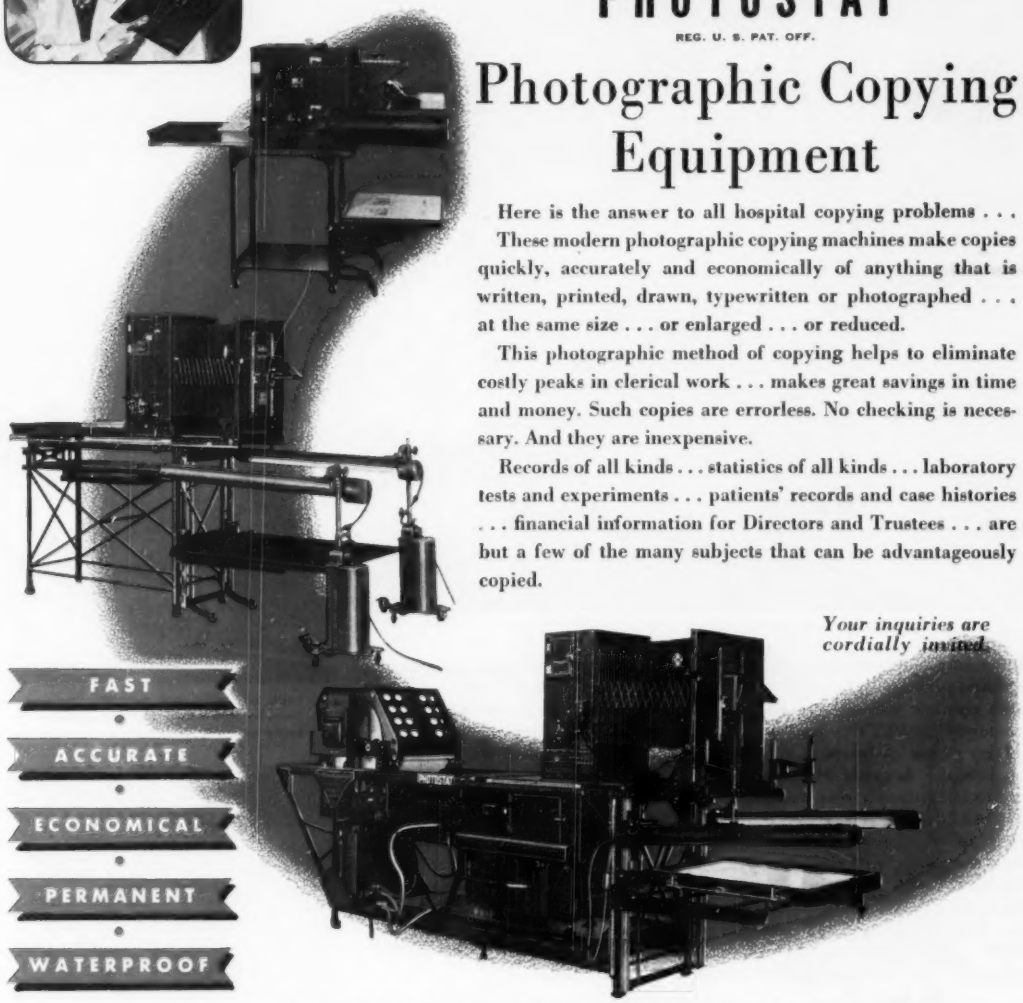
Here is the answer to all hospital copying problems . . .

These modern photographic copying machines make copies quickly, accurately and economically of anything that is written, printed, drawn, typewritten or photographed . . . at the same size . . . or enlarged . . . or reduced.

This photographic method of copying helps to eliminate costly peaks in clerical work . . . makes great savings in time and money. Such copies are errorless. No checking is necessary. And they are inexpensive.

Records of all kinds . . . statistics of all kinds . . . laboratory tests and experiments . . . patients' records and case histories . . . financial information for Directors and Trustees . . . are but a few of the many subjects that can be advantageously copied.

Your inquiries are cordially invited.



FAST • ACCURATE • ECONOMICAL • PERMANENT • WATERPROOF

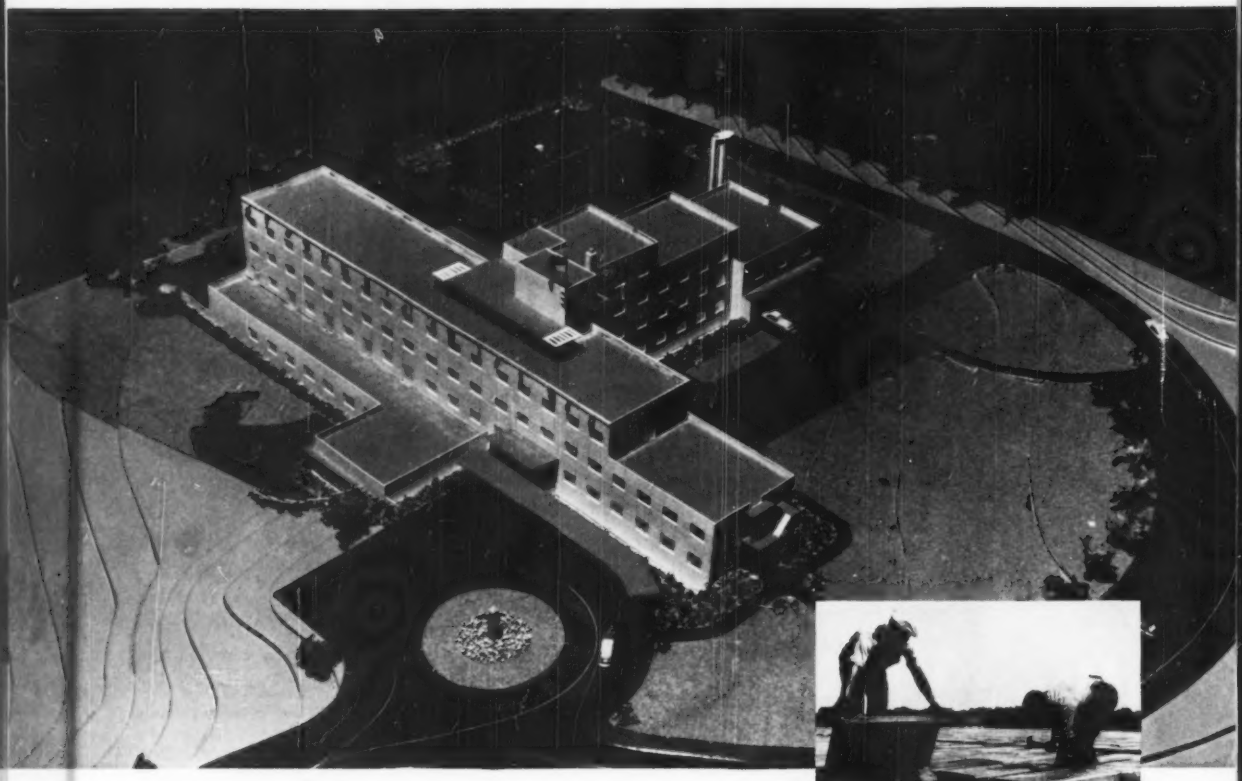
PHOTOSTAT CORPORATION

303 STATE STREET, ROCHESTER 14, NEW YORK

Service Offices in All Principal Cities

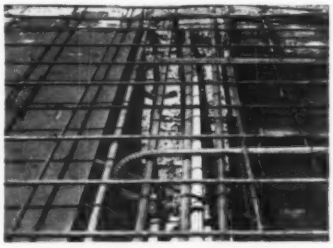
PHOTOSTAT is the trade mark of PHOTOSTAT CORPORATION

Strong Enough to resist an *Earthquake*



Labor of placing and removing steelforms by skilled Ceco workmen is ordinarily included with the rental charge.

There's one word usually associated with hospitals—"QUIET." But there's another word that's equally important—"SAFETY"—and it covers every phase of hospital activity. So, when the Sequoia Hospital of Redwood, California was designed, extra consideration was given the matter of construction methods. Here's where Ceco Concrete Joist Construction met the need. It provides strong, rigid floor construction. Yes, construction strong enough to resist an earthquake—shockproof yet flexible enough to absorb great strain—safe again since it's fire resistive. And Ceco Concrete Joist Construction answers the need of "QUIET" in hospitals because it assures a soundproof building. All this is possible at definite savings—less labor, less concrete, less lumber. And since removable steelforms are used over and over again, from floor to floor, only a nominal rental is charged. As originator of the steelform method, Ceco is first in the field. So for concrete joist construction, call on Ceco, the leader over all.



Placement of Ceco reinforcing steel is detailed by our engineers and supervised by trained erection crews.

CECO STEEL PRODUCTS CORPORATION

General Offices: 5601 West 26th Street, Chicago 50, Illinois

Offices, warehouses and fabricating plants in principal cities

CECO STEEL ®

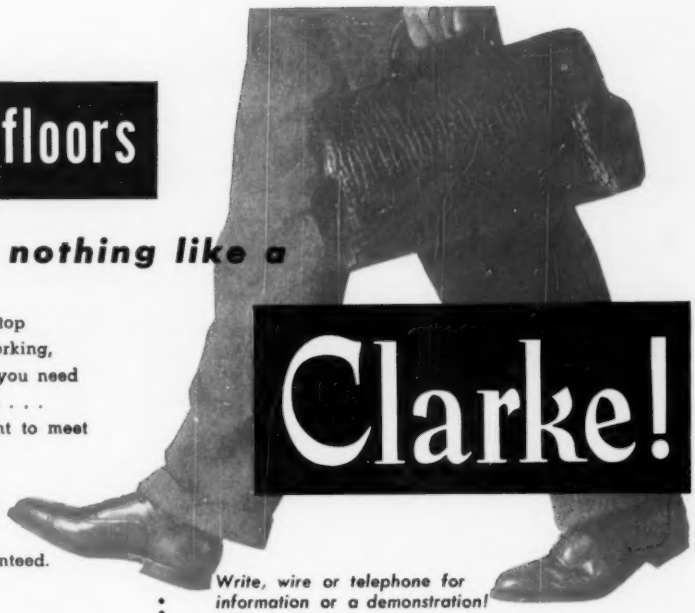
Douglas Dacre Stone & Lou B. Mulloy, Architects. Kingsford H. Jones, Associate Architect. Parker, Steffens & Pearce, Contractors.

In construction products **CECO ENGINEERING** *makes the big difference*

For hospital floors

. . . there's nothing like a Clarke!

It's easy to keep hospital floors in top condition — when there's a fast-working, quiet Clarke on the job! Whether you need specialized or all-purpose machines . . . Clarke has the floor care equipment to meet your needs . . . in sizes and models to fit your hospital budget. And **all** Clarke machines are quality-built to give years of dependable service. Liberally guaranteed.



Write, wire or telephone for information or a demonstration!

CLARKE
FLOOR MAINTAINER

Scrubs, waxes, polishes, steel wools and sands all floors, shampoos all carpeted areas. "Finger-tip" action safety switch. Adjustable handle to "fit" operator. Self-lifting wheels.

CLARKE
DUO SANDER-POLISHER

Sands, scrubs, polishes, buffs, wirebrushes, drills, grinds. Recommended for all types of hospital repair jobs. Lightweight, powerful, rugged.

CLARKE
HURRIKLEEN
ELECTRIC MOPPER

Picks up scrub water instantly! Floors dry in seconds. Ideal for use on large areas. Enables one man to do the work of ten men with ordinary mops.

CLARKE
HEAVY-DUTY PORTABLE,
WET AND DRY
VACUUM CLEANER

Quickly picks up water, dirt, dust! Quick-draining dump valve eliminates heavy lifting. Powerful suction . . . light, flexible, neoprene hose.

Clarke SANDING MACHINE COMPANY
5212 Clay Avenue
Muskegon, Michigan

Sales and Service Branches in All Principal Cities

WALTER REED HOSPITAL *(Army Medical Center new Out-Patient Department)*

is furnished throughout with cabinets, sinks and counters of seamless Stainless Steel equipment made by

ATLANTIC ALLOY INDUSTRIES, Inc.

At Walter Reed Hospital Out-Patient Department, the U. S. armed services have instituted the first actual diagnostic clinic, where a prospective patient's ills can be thoroughly analyzed before he is entered in the hospital.

Under the unification program an attractive, well appointed building has been furnished according to the clinical requirements of the types of service rendered. These services include prenatal clinics, pediatric clinics, under the general Department of Obstetrics and Gynecology; the Dental Clinic; Eye, Ear, Nose and Throat Clinic; an X-ray Department capable of X-ray diagnosis of the entire body; Superficial Therapy Section, and, throughout the entire clinic group, X-ray view boxes are placed to permit comparison of films and thorough examination of X-ray plates.

After a great deal of research, the Comparative Board decided that all equipment should be high quality stainless steel, because stainless steel is non-corrosive, sanitary, easy to clean, and does not show scratches, scars, or marks nearly so readily as does painted steel. Each piece of equipment was designed to be functional first, then to fit into the space which was available. Built-in cabinets and counters were selected to provide a minimum of maintenance over the life of the equipment.

Every unit was completely welded together to form a sanitary and strong structure. There are no cracks, seams, crevasses or bolt connections on working surfaces. Even the legs are solidly welded to the body to create the greatest possible rigidity and strength. A quarter century from now these units will still be good looking, sanitary, serviceable units that have required no repair or maintenance expenses.

Atlantic Alloy Industries, Inc. specialize in this type of high quality Stainless Steel Hospital Equipment.

Above — Stainless Steel Knee-operated scrub sink and stainless steel counter cabinets in Pediatric supply section Out-patient dept.

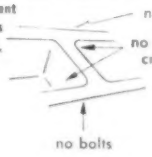
Below — Stainless Steel Wall Cabinets and Cantilevered Counters in OB-GYN Service, Out-patient dept.

Above—Stainless Steel cabinets counter and sinks in Pediatric Section Out-patient dept.

At left — Stainless Steel counters, sinks and cabinets in Orthopedic Examining and Utility room OPD.

Below — Stainless Steel Viewing Boxes, cabinets, counters, sinks, plaster bins and tables in Orthopedic Supply Section Out-patient dept.

Specialists in Stainless Steel Hospital Equipment welded into solid units without seams, cracks, crevasses or bolts.



ATLANTIC ALLOY INDUSTRIES, Inc.

35 Verona Avenue Newark 4, N. J.

NEW...and fresh as a breath of SPRING

for Comfort, Beauty and Long-Lived Service investigate

SHAMPAINE HOSPITAL BEDROOM FURNITURE

Soon to be available in three varied groups—deluxe, standard and dormitory—is this brand-new line of Shampaine All-Metal Hospital Bedroom Furniture which will include quality Englander hospital beds and mattresses. One glance will convince you that this is the type of bedroom furniture for which you have waited.

New designs offer unusual features. All drawers equipped with silent, all-steel slides, with super-quiet drawer stops. Never subject to expansion and contraction, thus will never stick. A wide variety of standard color schemes provides a broad selection suitable for any requirement. The clear, clean lines plus the charm of warm colors invite restful recuperation.

See your Surgical Supply Dealer now for further information, and send today for bed and mattress catalog now ready!

Sold through Surgical and Hospital Supply Dealers

SHAMPAINE CO. · SAINT LOUIS, MISSOURI

What features do YOU consider important in an instrument washer and sterilizer?

A HEAVY, WELDED STERILIZING CHAMBER of Monel and Lukens Nickel-Clad Steel is one of the features of this high-speed, hydraulically-operated American Instrument Washer and Sterilizer. Note wide-opening door. It permits rapid, safe removal of the loaded Monel trays, in which instruments have been washed, sterilized and dried in record time.

EASY TO LOAD. Cabinet-type design makes it possible to utilize standard instrument trays. Those furnished with the unit are made of long-lasting, corrosion-resisting Monel, and have wire mesh bottoms. Tray elevator has Monel frame and telescopic slide supports. Photos courtesy of American Sterilizer Co., Erie, Pa.

Do you look for speed? Safety? Simplicity of operation? Ease of cleaning? Freedom from maintenance problems?

Then take a *good* look at this pressure-type sterilizer. It's made by the AMERICAN STERILIZER COMPANY, of Erie, Pa.

With its heavy, welded sterilizing chamber of MONEL® and Lukens Nickel-Clad Steel, its solid MONEL trays and slide supports, and its many other features, the AMERICAN instrument washer and sterilizer is worth knowing about.

First, because it is *fast.* Here, for example, is what the manufacturer says about its speed: "This unit will process two full trays of instruments in 15 to 20 minutes. It handles washing, sterilization and drying – three jobs that take 1¼ hours or more by ordinary scrubbing and sterilizing methods."

Next, it's simple to operate. A single rotary valve controls all the progressive steps of the functional cycle. There's none of the possibility of confusion that's always present with multiple-valve sterilizers.

And–finally–this sterilizer brings you all the advantages of MONEL, the metal that never has to be pampered, even in exceptionally severe hospital service.

Monel takes hard, continuous use without complaint, for there's nothing to chip, craze, peel off or wear away. *Monel is solid metal.* It is strong . . . tough . . . hard . . . all the way through.

What's more, Monel is highly resistant to corrosion and staining. It stands up against heat, steam and moisture–against acids, alkalis and a long list of hospital solutions.

With Monel, cleaning is easy. Plain soap and water are usually all you need. But if you want to use cleansers occasionally, you needn't worry about hurting Monel. Remember, its good looks *last*–they can't be scrubbed away!

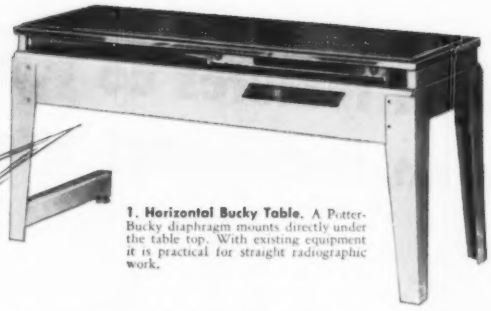
For detailed information about Monel-equipped sterilizer models, write AMERICAN STERILIZER COMPANY, Erie, Pa.

EMBLEM OF SERVICE

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street, New York 5, N. Y.

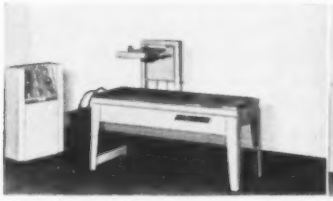
LOOK

what you get by adding to this basic Maxicon X-Ray Table

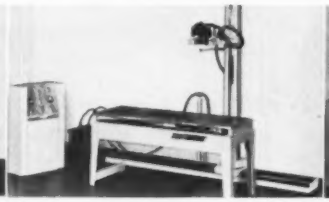


1. Horizontal Bucky Table. A Potter-Bucky diaphragm mounts directly under the table top. With existing equipment it is practical for straight radiographic work.

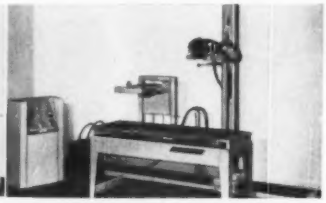
GE's Maxicon grows with the radiologist's needs, providing all these units—plus specialized combinations!



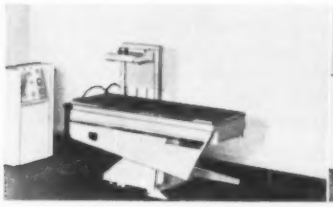
2. Horizontal Fluoroscopic Unit. The basic horizontal table can be converted for fluoroscopy by mounting a tube under the table and adding a fluoroscopic carriage screen unit.



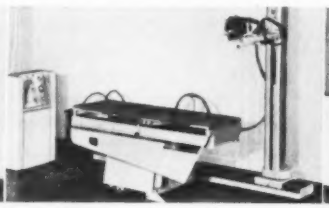
3. Horizontal Radiographic Unit. The horizontal Bucky table augmented by a stationary anode tube mounted on a tube stand and floor rail provides facilities for horizontal radiography.



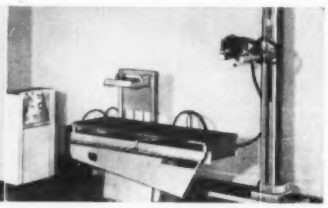
4. Horizontal Combination Unit. In this Maxicon combination, one tube serves as the x-ray source, over and under the table, for both radiography and fluoroscopy.



5. Hand-Tilt Fluoroscopic Unit. Fluoroscopy from Trendelenburg to vertical is easily accomplished with this unit. Panels in the table-front opening shield you from scattered radiation.

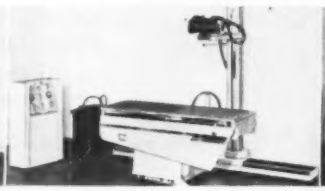


6. Hand-Tilt Radiographic Unit. Effortless angulation of table provides every facility for radiography in angular positions. The 100-ma generator and control complete the unit.

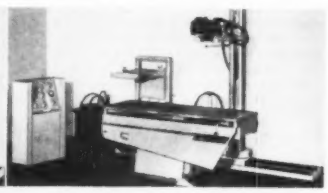


7. Hand-Tilt Combination Unit. The separate features of the radiographic and fluoroscopic models are combined in this unit to permit use of one tube for radiography and fluoroscopy.

8. Motor-Tilt Fluoroscopic Unit. Operator's hands are free, for palpation of patient and manipulation of controls. Scattered-radiation protection and automatic field-limiting device are important.



9. Motor-Tilt Radiographic Unit. Variable-speed angulation of the Maxicon table is controlled by two convenient foot pedals. All degrees of tilt from Trendelenburg to vertical are self-retaining.



10. Motor-Tilt Combination Unit. Gives complete radiographic and fluoroscopic service. Separate rotating-anode tube units, 200-ma generator and Maxicon control increase capacity of department.

Discover for yourself the remarkable flexibility of the Maxicon. Ask your GE representative for unique booklet demonstration, or write General Electric X-Ray Corporation, Dept. H12, Milwaukee 14, Wisconsin.

GENERAL ELECTRIC X-RAY CORPORATION

LET *COMPARISON* DECIDE . . .

To stress the importance of the proper type of flooring for hospitals is not necessary. Superintendents have long chosen rubber tile for better service in corridors, rooms, waiting rooms and dining rooms. But, to stress the importance of the kind of rubber tile *is* important. And only by comparing *all* brands, can the proper choice be made. So whether your plans call for remodeling or a new building program, make this comparison test now. And like so many superintendents, as well as leading architects, designers and contractors . . . men who *know* better flooring, you'll decide on Hood Rubber Tile, the floor that gives you a lifetime of wear, a new conception of beauty, a minimum of maintenance and years of vital quiet and comfort. Make *your* choice the choice of hospitals everywhere . . . Hood Rubber Tile. A free color catalog can help you decide. Write today!

B.F.Goodrich
Flooring Division
WATERTOWN, MASS

good antisepsis is on call too...

... and Zephiran chloride—safe and bacteri*cidal* antiseptic—goes wherever the physician's bag goes.

Zephiran is fast-acting and potent enough to kill hemolytic streptococcus, staphylococcus, Escherichia coli as well as other pathogens after a few minutes' exposure. Yet, at the same time, it is less toxic than mercurials.

Look at Zephiran any way at all and you will find it meets the requirements of a useful antiseptic. In your office or hospital, specify

Zephiran® *chloride*

effective,
safe,
economical
antiseptic

Supplied as:
Aqueous Solution 1:1000, bottles of 8 oz. and 1 U.S. gallon.
Tincture 1:1000, tinted and stainless, bottles of 8 oz. and 1 U.S. gallon.
Concentrated Aqueous Solution 12.8% bottles of 4 oz. and 1 U.S. gallon (1 oz. yields 1 U.S. gallon 1:1000 solution).

Winthrop-Stearns Inc., New York, N. Y., Windsor, Ont.

Zephiran, trademark reg. U. S. & Canada, brand of benzalkonium chloride refined 472M

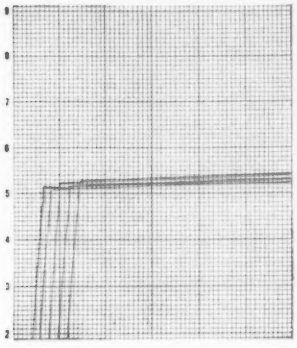
An advance in surgical silk . . .

NEW IMPROVED

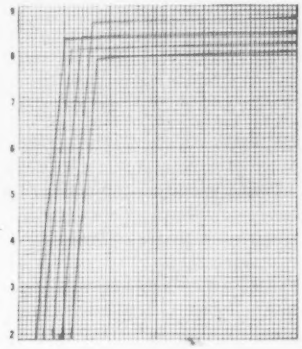
ANACAP®

SURGICAL SILK

Greater tensile strength — Improved Anacap Surgical Silk permits use of small diameters in all situations requiring silk. Tensilgrams show the difference between new Anacap and ordinary surgical silks.



An ordinary surgical silk meeting minimal U.S.P. requirements, size 00, breaks relatively easily when subjected to mechanical pull.



Improved Anacap Surgical Silk, size 00, has greater tensile strength, is much more resistant to breaking.

Can be sterilized repeatedly — In laboratory tests after 47 separate boilings, each of 30 minutes, size 4-0 Anacap Surgical Silk loses less than 0.2 pound tensile strength yet maintains absolute non-capillarity.

Flexible, not limp — New Anacap Surgical Silk handles as smoothly as fine flexible surgical gut. Never limp, it enhances surgical technic — speeds operative procedure.

Economical — Anacap Surgical Silk can be resterilized twice as often as many other silks.

In sizes 6-0 to 5 on spools of 25 and 100 yards; sterile in tubes with and without D & G Atraumatic® needles attached.

DAVIS & GECK, INC.

57 Willoughby Street Brooklyn 1, N. Y.

For Patients Allergic to Eggs, Wheat and Milk

BANANA RYE BREAD

(Egg, milk and wheat free)

- 2 cakes or packages yeast
- ¼ cup warm (not hot) water
- 1 tablespoon salt
- 1½ tablespoons sugar
- 2 tablespoons melted vegetable shortening
- 2¼ cups mashed ripe bananas* (5 to 6 bananas)
- 5¼ to 6 cups rye flour

**Use fully ripe bananas . . . yellow peel flecked with brown*

Dissolve yeast in water. Mix together salt, sugar, shortening and bananas. Add half the flour and beat until smooth. Beat in the dissolved yeast. Add remaining flour gradually and mix well.

Turn dough out onto a floured board. Knead about 8 minutes, adding just enough additional rye flour to prevent sticking. Place dough into a lightly greased bowl. Cover and let rise until double in bulk (about 2 hours).

Turn out again onto floured board and knead lightly about 2 minutes. Shape dough into 2 loaves. Place into lightly greased bread pans (8 x 4 x 3 inches). Cover and let rise again until double in bulk (about 1 hour).

Bake in a hot oven (425° F.) 5 to 10 minutes, or until crust begins to brown. Reduce temperature to 350° F. and bake 35 to 40 minutes longer, or until bread is done. Remove from pans. Brush top crusts with water. Makes 2 loaves.

All measurements used in this recipe are level.

Best Proof of Quality and Value—

MORE PEOPLE CHOOSE GARLAND

than any other range!

The New DINETTE
Model 38

Restaurant Range
Model 83

Restaurant Range
Model 84-7

COMPARE! See for yourself why GARLAND Leads the Field!

Garland sales leadership is a fact! And that fact is undeniable proof that *Garland* is the one outstanding name in commercial cooking equipment!

Yes, year after year more people choose Garland! And year after year Garland continues to top all other makes in performance, economy, dependability!

What's more, Garland production, by far the largest in the industry assures you of most-for-your-money value!

You owe it to yourself to see your Garland dealer before you buy. Let him show you in detail why Garland merits its position of leadership!

All Garland units are available in stainless steel and equipped for use with manufactured, natural or L-P gases.

Left to Right: All Hot Top—Open Top —Fry Top—Deep Fat Fryer—Broiler

GARLAND*

THE TREND IS TO GAS
FOR ALL COMMERCIAL COOKING

Heavy Duty Ranges • Restaurant Ranges • Dinette Ranges • Broilers • Deep Fat Fryers
Toasters • Roasting Ovens • Griddles • Counter Griddles

DETROIT-MICHIGAN STOVE CO.

REG. U.S. PAT. OFF. *Detroit 31, Michigan • Fine Ranges Since 1864*

new!

FOR GREATER CALORIC INFUSION

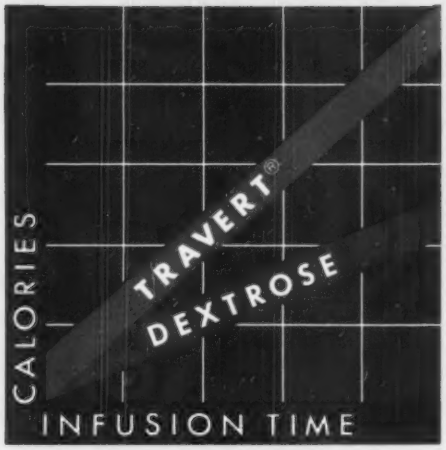
Travert®
(INVERT SUGAR, BAXTER)

metabolized at twice the rate of **DEXTROSE**

now!

since *Travert*®

is metabolized at twice the rate of Dextrose, it is possible and practical to approach complete carbohydrate alimentation



***Travert*®** (INVERT SUGAR, BAXTER) is another successful BAXTER *first*—a new line of solutions capable of supplying more than twice the calories of dextrose in equal infusion time, and without increased fluid volume.

Although it has usually been considered that dextrose could be metabolized at 0.85 gram per kilogram of body weight per hour,[1] recent studies have shown that if the dextrose is to be satisfactorily utilized, the rate of administration should not exceed 0.5 gram per kilogram per hour[2,3].

In comparison, ***Travert*®**, in recent tests, has been given clinically at the rate of 1.5 grams per kilogram per hour with practically 100 per cent utilization[4,5].

Therefore, twice as many grams of ***Travert*®** can be metabolized in the same infusion time as dextrose, providing the patient with twice the calories, and with equal comfort and safety.

BIBLIOGRAPHY

1. WOODYATT, R. T., SANSUM, W. D., and WILDER, R. M., *J.A.M.A.* 65:2067, 1915.
2. COOPER, D. R., IOB, V., and COLLER, F., *Ann. Surg.* 129:1, 1949.
3. LOCKHART, C. E., and ELMAN, R., *Surg., Gynec., & Obst.* 88:97, 1949.
4. WEINSTEIN, J. J., *M. Ann. Dist. of Col.* 19:179-182, 1950.
5. WEINSTEIN, J. J., *Ann. Western Med. & Surg.*, 4:373-377, 1950.

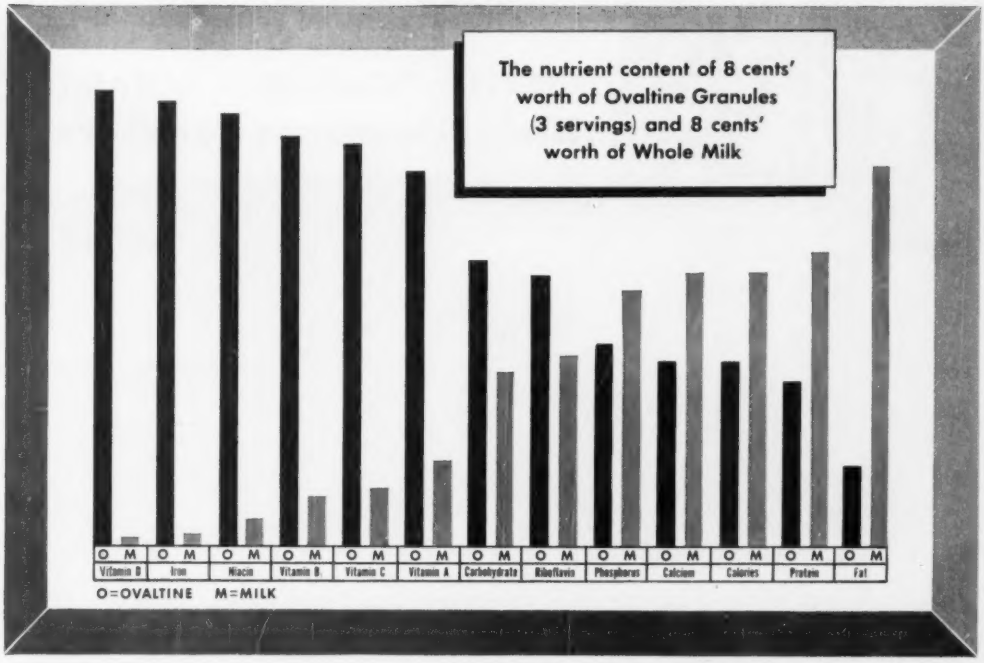
Two ***Travert*®** solutions are now available:
10% Invert Sugar w/v in water—and
10% Invert Sugar w/v in saline.

***Travert*®** solutions are sterile, crystal-clear and nonpyrogenic. Write today for literature and complete information.

Products of
BAXTER LABORATORIES, INC.
MORTON GROVE, ILLINOIS · CLEVELAND, MISSISSIPPI

Distributed and available only in the 37 states east of the Rockies (except in the city of El Paso, Texas) through

AMERICAN HOSPITAL SUPPLY CORPORATION
GENERAL OFFICES • EVANSTON, ILLINOIS



Note the *Outstanding Economy* of OVALTINE

NUTRIENTS	OVALTINE*	WHOLE MILK**
Vitamin D	400 I.U.	8 I.U.
Iron	12 mg.	0.3 mg.
Niacin	6 mg.	0.4 mg.
Thiamine	0.90 mg.	0.16 mg.
Ascorbic acid	30 mg.	4 mg.
Vitamin A	2025 I.U.	625 I.U.
Carbohydrate	29 Gm.	19 Gm.
Riboflavin	0.75 mg.	0.66 mg.
Phosphorus	255 mg.	363 mg.
Calcium	255 mg.	460 mg.
Calories	160	269
Protein	6.5 Gm.	13.6 Gm.
Fat	2 Gm.	15 Gm.

* 8 cents' worth of Ovaltine (3 servings)
** 8 cents' worth of milk

As the bar chart so vividly indicates, Ovaltine is an exceptionally economical source of many essential nutrients. Using whole milk as the basis for comparison, the chart contrasts the relative amounts of nutrients supplied by 8 cents' worth of Ovaltine granules (3 servings) and by 8 cents' worth of whole milk. In 8 of the 13 nutrients listed, Ovaltine supplies greater amounts, and in the remaining 5, high proportions of the amounts found in milk.

It should be noted that Ovaltine specially enriches milk in those nutrients in which milk is low. Thus Ovaltine is not only economical in use but constitutes with milk an ideal protective supplementary food drink. It finds wide usefulness whenever dietary supplementation becomes necessary, either because of poor appetite, inability to consume a normal diet, or illness which often makes normal eating difficult or impossible.

THE WANDER COMPANY
360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

CLEAN • COLORFUL • DURABLE
Blair Aluminum Furniture

A HAPPY blending of attractive styling, cleanliness and rugged durability makes Blair Aluminum Furniture the ideal for modern hospitals . . . Made of light but sturdy aluminum, welded throughout, with a rich satin finish that won't discolor, rust, chip or splinter. Generously upholstered on coil springs and covered with durable, dust-free Duran that cleans easily with a damp cloth, can't be harmed by childrens' scuffling feet and other rough usage . . . Available in a wide selection of cheerful colors.

Write today for full information on this complete line of hospital furniture.

Lounge Chair Model 1;
Settee Model 2;
End Table Model 45-A

In reception rooms, waiting rooms, or offices—wherever you need furniture—you'll find just what you want at a price you want to pay, in the complete Blair line.

BLAIR
Seats the Business World

THERE'S A BLAIR CHAIR FOR EVERY SIT-UATION

Blair Aluminum Furniture Company • Marietta, Georgia

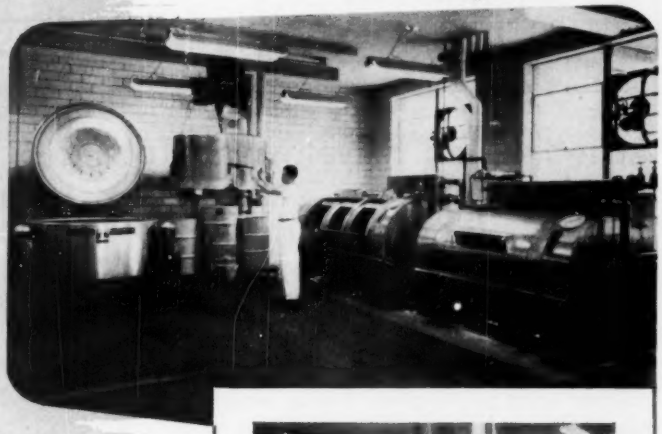
Congratulations to...

ST. JOSEPH'S HOSPITAL

ELMIRA, N. Y.

On Its Efficient, High-Speed Laundry Department

In bright, gleaming new laundry at St. Joseph's Hospital are 2 Monel metal CASCADE Washers **(right)** and NOTRUX Mechanically Loaded Extractor **(left)**.



PROBLEM: Before proceeding with planned expansion, this 291-bed hospital wanted to replace worn, labor-consuming laundry equipment with high-production machines of greater capacity.

SOLUTION: The problem was turned over to our Laundry Advisor. He analyzed present demands for clean linens and carefully estimated future requirements. Based on his wide experience, he prepared plans for a modern laundry department, equipped and arranged for time-and-labor-saving workflow.

RESULTS: Hospital now reports laundry production is on a fast, smooth schedule, completely satisfying clean linen needs of all hospital departments. Yet laundry work hours have been reduced and fewer operators are required. Quality of laundering is greatly improved.

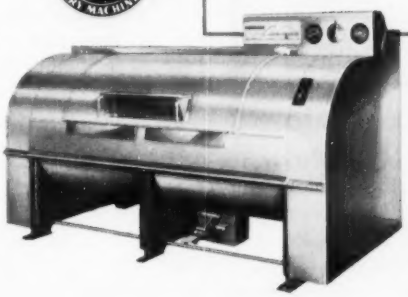
Free services of our Laundry Advisor are available to your hospital, large or small. WRITE TODAY.

REMEMBER . . . Every department of the Hospital depends on the Laundry.

Your hospital will benefit by selecting from our complete line of the most advanced and productive hospital laundry equipment.

Mass-production 8-Roll SYLON Flatwork Ironer with AIRVENT Canopy beautifully irons sheets and other flat linens at high speed.

These 2 NURSES' UNIFORM Press Units quickly and attractively iron uniforms for nurses and staff.



Modern, Monel metal CASCADE Washers at St. Joseph's Hospital have built-in "**2-Way Water Action**" which surges washing solution **up** through and **down** through work. Result, linens are washed snowy-white, sterile-clean in less time with big savings in water and supplies.

The
AMERICAN
LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO

Published by Clay-Adams Co., Inc.
141 EAST 25TH STREET, NEW YORK 10, N.Y.
Showrooms also at 308 West Washington St., Chicago 8, Illinois

Clay-Adams

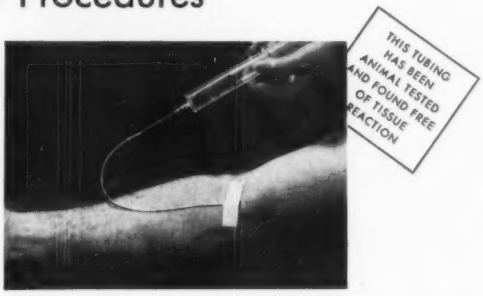
Animal-tested Polyethylene Tubing Simplifies Intravenous Therapy Procedures

Greater comfort to the patient, plus elimination of repeated venipuncture and dangerous tissue reactions, is now assured in intravenous therapy by using Clay-Adams animal-tested polyethylene tubing.

When using polyethylene tubing, which is soft, pliable and chemically inert, there is no danger of vein puncture and the patient's arm need not be immobilized. Hence patient discomfort is minimized.

Need for repeated venipunctures is also eliminated. Polyethylene tubing may be left in the vein and seals readily at the touch of a match flame. Should the need for additional infusions arise, the heat seal is cut off and additional fluids introduced without further puncture.

Polyethylene tubing is introduced into a vein via the lumen of a needle. Once inserted, the needle is withdrawn and the tubing fastened in place with a strip of adhesive tape. Because Clay-Adams polyethylene tubing is animal tested to eliminate tissue reaction, it has been

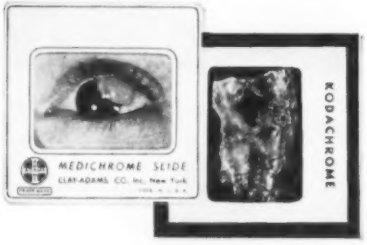


left in place as an in-dwelling catheter for as long as two weeks.

Polyethylene tubing is also finding wide acceptance in all procedures where in-dwelling catheters and cannulas are called for or would be advantageous, such as: caudal and spinal analgesia, drainage tubes, and a variety of experimental work.

Clay-Adams animal-tested polyethylene tubing comes in twenty-three tube sizes; different sized Luer-Lok couplers for coupling tubing to syringe are also available.

Medichromes Available for Most Medical Specialties



Regardless of your specialty, chances are that Clay-Adams probably has a Medichrome series to cover your field of interest. To mention only a few of the more than forty series available, there are Medichromes covering various aspects of the following specialties: clinical pathology, surgery, dermatology, gynecology, ophthalmology, urology, pediatrics. Subjects are covered from nursing as well as medical phases.

Medichromes are prepared from original normal and pathological specimens, microscopic and gross, under the guidance of a recognized authority in each field.

SPECIAL LITERATURE AVAILABLE

Detailed descriptions on the following may be obtained from Clay-Adams on request by number:

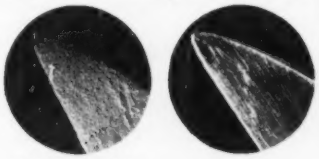
Rust Inhibiting Germicide	(503)
Polyethylene Tubing & Accessories	(447 B)
Kahn Trigger Cannula Outfit	(466)
Medichromes	(339 ML)

Newsletter

FOR THE BIOLOGICAL AND MEDICAL SCIENCES

New Rust Inhibiting Germicide Resists Rust, Film Formation on Instruments and Appliances

RIG concentrate, a new rust inhibiting germicide for the cold disinfection of medical instruments and appliances, protects costly instruments from rust or film even after six months' immersion in RIG, tests reveal. Photomicrographs below show the pitting and loss of cutting edge of a scalpel left in a germicide without rust inhibiting features *(left)*, and absence of such damage from a scalpel left in RIG *(right)*.



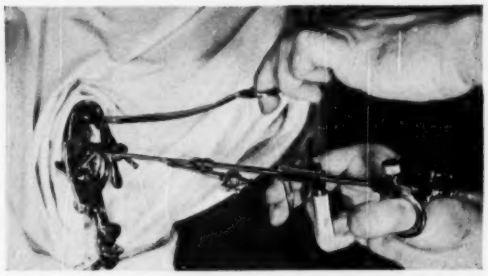
Ordinary Germicide RIG

Concentrated in 10 ml. ampules, each ampule of RIG diluted with soft *or hard* water, makes one quart of highly potent germicide. Germicidal and rust inhibiting features of RIG are retained until solution is discarded. RIG is also available in pint cans for hospital use.

RIG is colorless, odorless and stable, and contains no mercury, phenol or formalin. RIG may be safely used on metal, rubber, plastic or glass instruments and appliances.

You may be interested...

- Determination of the VPRC (Volume Packed Red Cells) for the Wintrobe Sedimentation Test with the Adams Safety Head Centrifuge (Model CT-1002) was found to be 50% more efficient than the conventional free-swinging type operating at the same speed.
- Small size 1½" Dieffenbach Serrefines, favored by experimental biologists for animal surgery, are again available.

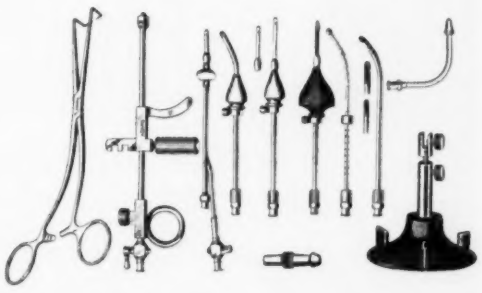


Versatile Cannula Outfit Adaptable to Many Gynecological Procedures

The new versatile self-retaining Kahn Uterine Trigger Cannula Outfit, complete with interchangeable tips, is well-suited for many gynecological surgical procedures. It has found wide acceptance for tubal insufflation, uterosalpingography, hysterometry, endometrial biopsy.

Basically the outfit consists of a universal trigger handle, an improved style traction tenaculum and a series of interchangeable tips.

Cannula and tenaculum of the Kahn Trigger Cannula Outfit are engaged by a trigger device, permitting one-hand control and simultaneous "push" and "pull" on cannula and tenaculum. The uterus is not displaced: the two opposing forces are synchronized and balanced. The tenaculum is designed to minimize danger of a tear through the cervix.



Clay-Adams Company, Inc. 141 EAST 25TH STREET, NEW YORK 10, N. Y.

CLAY-ADAMS PRODUCTS DESCRIBED ON THESE PAGES ARE AVAILABLE FROM LOCAL SURGICAL SUPPLY DEALERS

Small Hospital Questions

Laundry Cost per Pound

Question: Can you tell us the approximate cost per pound for processing laundry in a small hospital operating its own laundry equipment?—M.W.W., Ore.

ANSWER: We have just received the accompanying current cost table from a 75 bed hospital which recently installed its own laundry equipment.

		Cost to Operate	Pounds Processed	Cost per Pound
February	1950	$ 819.77	17,550	$0.04670
March	1950	870.41	20,020	0.04348
April	1950	888.77	19,500	0.04557
May	1950	958.71	22,000	0.04358
June	1950	882.33	21,850	0.04335
July*	1950	941.90	19,650	0.04794
August	1950	848.57	21,550	.004401
		$6,210.46	142,120	$0.04361

*Including maintenance charge of $108 to repad the 100 inch, two roll iron.

Smoking in Bed

Question: Can you tell us whether hospitals have had serious fires or suffered considerable losses in property damage from fires caused by patients smoking in bed?—E.W.A., Iowa

ANSWER: A report released early in 1950 by the Fire Protection Institute indicated that smoking and matches were responsible for 21 per cent of institutional fires. Other major causes of institutional fires were reported as misuse of electricity, defects in heating systems, spontaneous ignition, inadequate rubbish disposal, friction and static sparks, in that order.

A check with the claims department of a large Midwest insurance company, however, reveals that, in the experience of this company at any rate, fires caused by patients smoking in bed have not usually been serious. "A check with our fire loss manager," said an executive of this company, "verifies the fact that we have had no serious losses due to this cause, although he does recall several small claims for damaged bedding and mattresses."

Conducting a Fund Drive

Question: We are contemplating a campaign for funds to finance an addition to our hospital. Is it advisable to employ a professional fund raising director?—J.M.B., Ill.

ANSWER: The following statement—taken from an article that appeared in The MODERN HOSPITAL many years ago—still seems to cover the subject thoroughly.

1. No campaign should be entered upon until a competent, disinterested person or organization has first determined by a local survey of the community's needs that the proposed hospital or addition to a hospital is necessary. Moreover, the facts which establish the claim should be submitted to the public for review. This will serve to assure the public of the soundness of the investment it is asked to make.

2. The campaign director should not be employed on the strength of hearsay evidence or of any printed matter he may issue as to his capabilities. A thorough critical investigation should be made, both of the man and of his methods.

3. The hospital's campaign committee and not the campaign specialist should hold itself responsible for the campaign, the persons conducting it, and any official statements or promises made during it.

4. The campaign committee should guarantee all the expenses of the campaign, and pay its director a salary. Commissions should be frowned upon. The desire to increase their income may tempt campaign specialists to obtain contributions by measures that react most unfavorably upon the hospital and its place and influence in the community. Employing a director on a commission basis, moreover, gives unwilling contributors an opportunity to assert that if they contribute to the hospital during the campaign a portion of their gift will go into the pockets of the campaign specialist. Rather than have this happen they will refrain from giving altogether.

5. A finance committee should keep an accurate record in detail of the monies pledged, and the funds received during the campaign. For obvious reasons this should not be the responsibility of the campaign director. At the end of the campaign the records should be audited by a certified public accountant, and the reports submitted either to the contributors or to the public at large.

It is believed that if hospitals will consider these suggestions in organizing and conducting their financial campaigns, they will have fewer failures to report and will win many steadfast friends.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Records and Charges

Question: (1) How long can a short-form record be used without addition of personal history and progress notes? (2) What do hospitals usually charge for the use of a baby incubator per day?—M.G.Y., N.M.

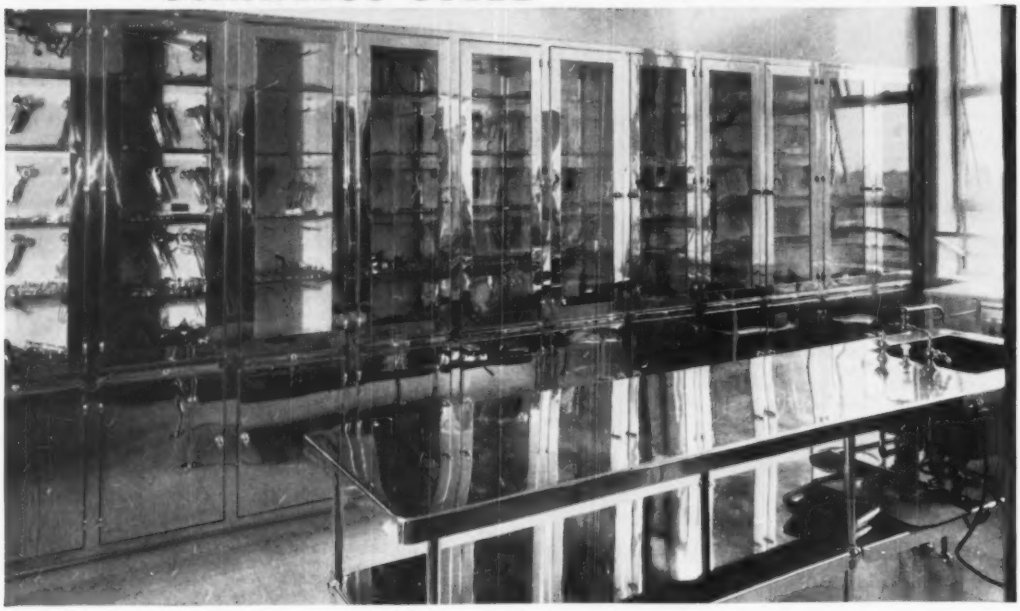
ANSWER: 1. It is impossible to give an accurate answer on the short-form record without seeing a sample and knowing just how the form is used. You should study the sections on medical records in Dr. Malcolm T. MacEachern's book, "Hospital Organization and Management." Permanent medical records should meet these standards. There is no substitute in a medical record for a good personal history and systematic, thorough progress notes. The medical record should be completed and signed by the attending doctor within one week after discharge of the patient. At most, it must be done within one month of the patient's discharge.

2. Hospitals generally do not make a separate charge for the use of baby incubators. However, it is becoming the practice to have a regular charge per day for the new-born baby in the obstetrical department and nursery. This charge is often set at one-fourth or one-third of the regular day rate charged the mother.

Enduro®
STAINLESS STEEL

THRIFTY METAL OF 10,000 USES

28 ENDURO Stainless Steel cabinets are inset in walls of this instrument room. 19 years of heavy and continual use have shown no flaw nor trace of wear in their glistening surfaces. Sanitary ENDURO also is used for surgical instruments and work tables. More uses for long-lasting ENDURO include autoclaves and sterilizers, food preparation and serving equipment, operating tables, therapy tanks, wheeled stretchers, kick-plates, laboratory equipment, piping and tubing.



SPARKLING WITH BRIGHT IDEAS...

You've seen ENDURO Stainless Steel sparkling in many a morning sun—its very appearance a picture of complete cleanliness . . . sanitation . . . competence.

ENDURO is in hospitals to stay.

No wonder. ENDURO equipment has an apparently limitless future. The instrument cases shown here still sparkle brilliantly today, after almost twenty years of heavy and continual use.

Who can estimate the future service possibilities of this steel which ignores the years?

And, why not apply its unusual values more generously?

ENDURO window frames and sills and ENDURO radiator covers, for example, could be equally attractive, durable, sanitary and easy to maintain. Then, atmospheric conditions would neither rust nor corrode them. Radiator heat would not smudge them. Unavoidable bumps and scrapes would not deface them.

ENDURO improvements like these are open to you now! Equipment manufacturers are supplying thousands of sanitary, easy-to-clean stainless steel items for hospital use. Competent local fabricators can help you work out practical ideas for special equipment. Costs can be recovered quickly through sharp reductions in maintenance and replacement expenses.

Call your Republic District Sales Office, or write us for more information and for your free copy of the interesting booklet, "Enduring Hospital Sanitation with Republic ENDURO Stainless Steel."

✓ **CHECK ALL 10 ADVANTAGES:** Rust- and Corrosion-Resistance • Heat-Resistance • High Strength • No Metallic Contamination • Sanitary Surfaces • Easy to Clean • Eye Appeal • Easy to Fabricate • Long Life • Low End Cost • *What more can be desired in a material?*

REPUBLIC STEEL

For Complete Details Write

REPUBLIC STEEL CORPORATION

Alloy Steel Division, Massillon, Ohio • **GENERAL OFFICES, CLEVELAND 1, OHIO** • *Export Dept.: Chrysler Bldg., New York, 17, N.Y.*

MEET HIGHLY SPECIALIZED FLOOR REQUIREMENTS WITH

Plastic-Asbestos Flexachrome

Flooring specifications for hospital x-ray rooms were extremely troublesome . . . until Flexachrome* provided a simple solution to this complex problem. Its unusual versatility makes Flexachrome suitable for many other flooring needs, too.

Because it's truly *greaseproof,* you can use Flexachrome in kitchens, dining areas, compounding rooms . . . anywhere grease creates a problem.

Cost-per-square-foot-per-year is a surprisingly low figure. One reason for this is quick, easy installation. (The unusual flexibility of the tile allows a firm, fast, permanent bond to the sub-floor.) Another is Flexachrome's extraordinary durability. A third is simple, economical maintenance. Flexachrome retains its brilliant beauty under most rigorous service merely with daily sweeping to remove loose dirt, periodic washing and water-waxing (if desired).

And what scope you have in design! The individual tiles can be laid in an almost endless variety of patterns. Functional designs influence traffic, identify departments, enhance safety. Decorative motifs add striking individual beauty to interiors. Custom-cut inserts create truly unique floors.

Flexachrome is unsurpassed for color, too. 33 rich, vivid colors enable you to carry out any decorative mood you wish... gay and bright, or dignified and subdued.

You'll want complete information on Flexachrome, it's yours for the asking. Write us: THE TILE-TEX DIVISION, The Flintkote Company, Dept. H, 1234 McKinley St., Chicago Heights, Ill.

Tile-Tex
PLASTIC-ASBESTOS
FLOORS AND WALLS

Other Tile-Tex Flooring Products include: Mura-Tex Plastic-Asbestos Wall Tile; Tuff-Tex* Heavy Duty Greaseproof Industrial Tile; Tile-Tex*. . . the* Quality *Asphalt Tile.*

*REGISTERED TRADEMARK, THE FLINTKOTE COMPANY

THE ARMSTRONG X-4 BABY INCUBATOR IS STILL LOW IN COST STILL LOW IN OPERATING COST

THE GORDON ARMSTRONG COMPANY, INC.

To Hospital Administrators:

ABOUT PRICES

I'm writing you this memo October 9th to appear in all of our December advertising. By the time you read it anything can have happened but regardless of conditions in December our basic thinking will be the same. We shall fight against any increase in our selling price. This goes for any product we design and sell and applies particularly to the Armstrong X-4 Baby Incubator.

For 7 years now we have done this and in 7 years we have increased our Baby Incubator price less than 3 and ½ per cent and we have sold over 12,000 Baby Incubators. That's a record we're proud of. We shall keep on fighting costs.

Here is our pledge to you. We will not increase the price of the Armstrong X-4 Baby Incubator except as a last resort. As time goes on we may be forced to because we simply can't help it but we do not see it yet and we shall continue to fight against it.

Don't be "panicked" into buying anything. Don't order Armstrong X-4 Baby Incubators just because some other prices are going up. When you need Baby Incubators then buy an Armstrong X-4 because the price is low, because it is so easy to operate, because it is simple and safe and because back of every Armstrong X-4 Baby Incubator is 12,000 Incubators worth of experience.

We're both washing our necks in the same bucket you know—we're in this fight together. You can help us win by continuing to give us your loyalty and support just as you have for the past 7 years. Trust us to do our part.

Sincerely yours,

The Gordon Armstrong Company, Inc.

Gordon Armstrong

Gordon Armstrong
Pres-Treas

WHEN the Armstrong X-4 Baby Incubator was designed, we worked to keep both costs low for Armstrong X-4 users.

Low *first* cost has been accomplished by the elimination of unnecessary selling expense. Savings we have made in selling costs are passed along to X-4 users by holding down the price. As a matter of fact our price has increased less than 4% in seven years.

Low *operating* cost is accomplished through clean, simple design and easy control, with replacement parts for those that wear out in normal use available at low prices.

But these factors do not mean that the X-4 is cheap in *any* sense. All important construction materials and controls used throughout the X-4 are the finest on the market.

So, remember, the first cost on an X-4 is low, the operating cost is low. As long as it is humanly possible, we intend to keep it that way, as the users of over 12,000 Armstrong X-4 Incubators will tell you. Write for a complete description of the X-4 and you'll quickly realize why.

ACCEPTED COUNCIL ON PHYSICAL MEDICINE AMERICAN MEDICAL ASSOCIATION

C.S.A. APPROVAL NO. 7307

LISTED UNDER EXAMINATION SERVICE OF UNDERWRITERS' LABORATORIES, INC. UL

THE GORDON ARMSTRONG COMPANY, INC.

Division DD-1 Bulkley Building, Cleveland 15, Ohio

Distributed in Canada by Ingram & Bell, Ltd.

Toronto • Montreal • Winnipeg • Calgary • Vancouver

"Back of every Armstrong X-4 Baby Incubator is over 12,000 incubators' worth of experience."

Looking Forward

Toward the Common Object

MEETING in Chicago last month to continue their discussions of hospital standardization, representatives of the American Hospital Association, the American College of Surgeons and the American Medical Association moved a step closer to development of a joint standardization program. With the American College of Physicians as a fourth participant in the enterprise, the group appointed a subcommittee to work out details of a cooperative plan.

This is good news. As has been noted before in these pages, the cooperative approach to hospital standardization would certainly appear to offer the best way to effect a program that can concentrate on the objective of improving patient care in every possible way at the least expense of time and effort. A unilateral approach by any one of the interested organizations would have necessarily resulted either in an incomplete program or in jurisdictional disputes about lay judgment of professional performance, or vice versa. The prospect of having several standardization programs run by several organizations was a nightmare to most hospital administrators, whose lives could easily have become an endless succession of questionnaires and inspection visits.

The argument against a cooperative program—that standardization was administratively too complicated to make a joint program practical—was always pretty lame. The Associated Press, which operates a fairly complicated worldwide newsgathering and reporting service, is a cooperatively owned and managed enterprise supported by not three or four but hundreds of participating newspapers. The United Nations is a cooperative agency whose problems compare favorably, from the standpoint of administrative complexity, with those presented by hospital standardization. Certainly it should be possible for the participating organizations to agree on principles of operation and an administrative structure within which an executive staff can operate effectively to achieve the objectives all are interested in accomplishing.

As a matter of fact, in this case it might be sensible to carry the cooperative concept beyond the limits of support and policy making, into actual operations. As the hospital planning authorities in the state health departments have developed under Public Law 725, their staffs have emerged in many instances as trained observers and judges of hospital procedures—functions which will be carried still further in those states having hospital licensure programs. Here is a nucleus around which the inspection service for standardization might be built—of course with standards being established by the central, voluntary approval authority that is now contemplated, and with final evaluation of hospital performance in the hands of the voluntary rather than any state agency.

Whether this is done or not, events are now moving in a direction which promises a more satisfactory solution than seemed possible a couple of months ago. Open discussion looking toward the compromise of conflicting aims and interests is the core of the democratic method. By this method the groups interested in hospital standardization have demonstrated once again the truth of Cardinal Newman's proposition: "When men combine together for any common object, they are obliged, as a matter of course, in order to secure the advantages accruing from united action, to sacrifice many of their private opinions and wishes, and to drop the minor differences, as they are commonly called, between man and man."

Prophecy

IN A paper presented at a scientific symposium celebrating the opening of new laboratories by the Sterling-Winthrop Research Institute, Dr. William Dock of Long Island College of Medicine reminded his fellow physicians of the old Roman warning that "Fate leads the willing but drags the unwilling." Then, in words that medical and hospital people everywhere should consider thoughtfully, Dr. Dock urged physicians in the United States to accept leadership in reorganizing medicine into patterns suitable for this century.

"The physician must look beyond the picture, now widely cherished, of the lonely, great hearted doctor, bowed impotent beside the dying child," Dr. Dock declared. "Modern transportation, modern methods of communication and modern technics of diagnosis and treatment have made that picture as obsolete as the village blacksmith at his charcoal forge. Organized medicine has fought hard to prevent inroads on the domain of the general practitioner. Our profession has resisted the Twentieth Century more successfully than the grocers have resisted the chain stores, or the cartwrights resisted the automotive industry. But, in the

end, obsolete methods must be replaced or the whole system will be swept away.

"Doctors must work together in teams, varying in size and complexity to suit their communities," Dr. Dock continued. "The family doctor of the future will be the member of the team who brings to a focus on each family the preventive phase of medicine, the prompt management of readily controlled illness and the early detection of the need for special study and intervention. Whether medical care is paid for like furniture and automobiles, or by voluntary insurance like automobile damage, or by compulsory insurance, like automobile liability in some of our states, or whether it is provided for those of limited means by the county, as it is today with conspicuous success in many states, in the end the most effective service will have to be provided by competing teams of doctors. Some teams may have only three or four members, others may have hundreds. Many such teams will be developed around our present hospitals, medical schools and industrial medical centers. Others must be fashioned to meet community needs. The more of these founded by doctors and sponsored by medical societies, rather than by politicians, the better."

Dr. Dock's prophecies may be labeled heresy by those who cling to the concept that group practice is somehow less professional and ethical than individual practice. But the shift toward team practice is already so far accomplished that even the most rugged individualists in medicine depend to an important extent on their colleagues and assistants in the hospital, and generally it is where the team spirit is most highly developed that results are best. In medicine as in our economic society, increasing complexity is a product of scientific advancement. Since the time of Pericles and Hippocrates, this trend has been irreversible. Those who are willing to move along with it now can still be led by fate. Those who aren't will surely be dragged—if they are not tramped on.

Substitutes

THE modern general hospital is the unexcelled possessor of the best in medical diagnostic and therapeutic staff and equipment. It has no equals and no competitors within the range of its activity. There are good hospitals and better hospitals, but there is no other resource in the community that can be accepted as a substitute for the general hospital. The history of medical care provides ample evidence that no other type of community agency has ever been equally successful.

Homes for the aged, homes for the incurable, nursing homes, and a variety of other institutions with a catch-all admission policy based, under the stimulus of humanitarian impulse, on the exclusiveness of the general hospital, cannot be expected to substitute for the general hospital. Necessarily, they lack the highest quality of specialized staff and equipment which must be available at all times in an accessible area. They must lean heavily on the general hospital for support when they require that which only the general hospital can provide—a more frequent circumstance than appears on the surface.

There is, however, an even stronger reason why these institutions cannot hope to offer themselves to the public as substitutes for hospitals. As was pointed out some time ago by Dr. E. M. Bluestone,* these institutions, which house far more of the sick population than they should, in view of their frequent shortcomings, are, in fact, substitutes for the patient's home and not substitutes for the general hospital.

A sick man must be in a position to look to one of three locations in his trouble, in accordance with his needs—the general hospital, his home, or a substitute for his home. Since the general hospital has the best in medical science at its disposal, it should have authority in all three locations—with the cooperation of the family physician if the patient can afford his services, or without his cooperation if he cannot. We can have substitutes for the patient's home, but there can be no substitute for the general hospital.

Not Hard to Choose

A SURVEY of hospital equipment manufacturers in one section of the country last month revealed that scarcities are showing up with increasing frequency in many kinds of steel and in aluminum and other nonferrous metals. The sales manager of an electrical supplies manufacturing company reported that his telephone is busy all day as customers call to plead for more material. His system of prorating available supplies on the basis of past purchases doesn't begin to meet current demands, he said, and the backlog of unfilled and unfillable orders is mounting relentlessly.

Obviously, shortages of needed equipment for the many new and expanded hospitals now under construction or in contemplation are coming, if they are not actually here. Serious disruption of the entire national hospital program will follow quickly unless measures are undertaken right away to keep necessary materials flowing into the hospital market. What is called for is a priorities system giving hospitals and their suppliers top rating after actual military needs. Unquestionably, enforcement of any such system now would result in some hardship on other types of public enterprise and on many private industries, and these groups could be expected to protest that they were being regulated out of business.

In the interest of public safety, this protest must be risked. The hospitals that were essential for a growing peacetime population will be even more urgently needed if there should be a war. In a period of preparedness, the choice between guns and butter is always difficult for a nation to make, but it should not be hard for us to choose between bedpans and bicycles.

* Bluestone, E. M.: Social Medicine Arrives in the Hospital. Mod. Hosp. 75:2 (August) 1950.

BOTH SIDES COULD BE WRONG in the DOCTOR-HOSPITAL CONFLICT

From the vantage point of active contact with both groups, this author analyzes reasons for medical-hospital tension, and suggests a long-term solution. For the clinician's point of view, turn to page 44

MARTHA O'MALLEY, M.D.
Director
Division of Hospital and Institutional Services
Indiana State Board of Health
Indianapolis

IT IS apparent to anyone close to hospitals that the highest level of cooperation does not always exist between hospital administrators and medical staffs. Attendance at any meeting of hospital administrators in which medical staff relationships are discussed reveals that a high level of respect does not always exist on the part of many administrators toward their medical staffs. Physicians are criticized for their apparent lack of interest in and their seeming unwillingness to cooperate in finding the solution to hospital problems. At the same time, when hospital problems are discussed with physicians, it is apparent that many physicians do not understand their hospital administrator or hold him in high regard. They particularly criticize hospital administrators for not permitting them to have sufficient voice in hospital matters.

It hardly seems necessary to say that it is imperative to the professional people involved, to hospitals as institutions, and to the public that harmony of purpose and action prevail, and that hospital administrators and the medical staff have an equal responsibility for determining whether or not their relationship will be one of cooperation or competition. But it is important that cognizance be taken of the fact that not infrequently harmony is absent and no one feels responsibility for improving the situation. This lack of harmony weakens the status of both the administrator and the medical staff. Cooperation strengthens each group or party individually and collectively.

There are undoubtedly many reasons on the part of hospital administrators and medical staffs for not being able to carry out their relations in a cooperative manner. The intention of this paper is to explore frankly the existing situation and to offer suggestions in the hope that leaders in both fields will take greater cognizance of the situation and direct their efforts to a solution satisfactory to hospital administrators, physicians and public.

In considering their reasons for lack of cooperation, it is found that one of the outstanding factors contributing to this situation is the lack of knowledge on the part of the majority of practicing physicians as to the principles involved in good hospital administration and medical staff organization. All too many physicians fail to realize that the true purpose of staff organization is to provide a structure to ensure self-government of the medical staff in professional matters and a means whereby an organized united approach to problems will be assured. Proper organization outlines responsibilities of both staff and administration and ideally the two approach problems as a harmonious team.

In a recent survey in one state, it was found that 50 per cent of all hospitals had no hospital medical staff organization. Failure on the part of staffs to organize appeared to be attributable to the lack of appreciation of the need for and value of staff organization. Also there appeared to be a lack of knowledge on the part of medical staffs as to how to effect an organization. It is sometimes assumed that background in this field is supplied as a part of the physician's formal professional preparation.

That this is not true was apparent in a recent discussion of the relative responsibilities of the hospital board, the administrator and the medical staff that I had with a group of senior medical students in a recognized medical college. In this group there was only an occasional medical student with any appreciation of the fact that the medical staff did not have the complete authority for directing the entire hospital program. Even though the vast majority was under the impression that the physicians had this authority, it had no idea of how this responsibility might be met. It was also found that after discussing the relative authority and responsibility of the governing board, the hospital administrator and the medical staff, the reasonableness of the principles of hospital organization and administration was apparent to the students. It may be noted in passing that these students were vitally interested in learning more about hospital operation and management. A repeated expression by them was "Why didn't someone tell us about

(*Continued on Page 46.*)

Speaking for the Medical Staff

FREDERICK T. HILL, M.D.
Medical Director
Thayer Hospital
Waterville, Me.

A FEW months ago I was in a Western city attending meetings of my special medical societies. One morning I went down to breakfast in the hotel with two good physician friends of mine. During the course of the meal the conversation, as is perhaps inevitable these days when physicians get together, led up to a discussion of this problem of government controlled, or socialized, medicine. I made the statement, which I firmly believe, that if we were to preserve our voluntary system which has done so much to develop the highest standards of practice in the world today, it could only be done by the active and earnest cooperation of both the medical profession and the hospitals. Much to my surprise one of my friends, a person prominent in his profession in his home city, stated that he feared the hospital people much more than he did any of the activities of the politicians in Washington; that he was more suspicious of them and of their aims.

TRUSTEES BECAME BITTER

Sometime before this I had been asked to sit in conference with two trustees from a fine hospital here in the East, where they were having what they called "staff troubles." In the course of the discussion both of these gentlemen became so bitter in their denunciation of the staff that I felt impelled to state that, apparently in their opinion, all of their hospital troubles would be solved if they didn't have to have any physicians in the institution. Without any hesitation they both agreed that that might well be so.

Now, of course, these are extreme cases. Nevertheless, they give us pause to think, because, beneath it all there is something which makes us a bit uneasy about the situation of our hospitals, particularly the relations among the various groups that work in and for them. Frankly, I feel that there has been altogether too much emphasis placed upon the subject of "staff problems." How often do we see this topic on the programs of hospital meetings? Apparently, in the minds of many, the physician has become the problem child in the hospital family and perhaps not without some reason. However, this term implies an antagonism which should not be emphasized and brought to the fore again and again. Personally, I much prefer the term "staff development" which, at least, is constructive.

Those of us who work in hospitals —doctors, administrators, trustees and nurses—all have, or should have, the same ideals and the same objectives. To be sure, there are certain difficulties inherent in any hospital organization, dealing as it does with such divergent personalities as administrators, trustees and doctors. But these are difficulties which should be overcome by mutual understanding and cooperation. We must recognize that the doctor, by nature, is the executive type. He would not be a good doctor if he were not. And this characteristic is further developed by his education and his training. This, then, brings up a problem of multiple executives in the hospital organization, and sometimes seems to conflict with these formal tables of organization so often referred to in hospital literature. While these are valuable and necessary there may be, at times, a too rigid adherence to these formal plans and blueprints of lines of authority. Sometimes a little flexibility, if intelligently applied, may be worth while.

Let us consider, for a moment, just what sort of person is this doctor whom we must have in the hospital, if it is to function as a hospital. First, he is intensively individualistic. He is made so by his training and his experience. He is forced to make his own decisions, often with finality, in contrast, say, to the lawyer. The latter has been termed the man of discussion, while the doctor is called a man of decision. The physician, confronted with problems involving life, or health, cannot file briefs to be submitted to the Supreme Court for further decision. He must make his own decision, and often without delay.

He is proud and, therefore, is likely to resent criticism. Naturally he is proud of his profession. He would not be a good doctor if he were not proud to be one. To be sure he should not resent constructive criticism but sometimes it is difficult for him to recognize that it is constructive. And sometimes, he has a "Messiah" complex, something which is certainly disastrous to harmonious relations in the hospital. Now this may not be entirely his own fault. Many times he may be spoiled by certain of his patients. He may be the object of extreme adulation, perhaps resulting from something of a very minor nature; but, being human, he just naturally likes it. On the whole, however, he is really a pretty good fellow. We must recognize that his primary interest is in his own patients and we would not have it otherwise. Nevertheless, it sometimes would be helpful if he would show a similar interest in all the hospital's patients. That could best be brought about by a better understanding of the aims and ideals of the institution. And he is the sort of person who can be led but not driven.

EMPHASIZES NEED FOR COOPERATION

Now, this sort of person, this doctor, who by training, inheritance and experience has these characteristics and, by nature, is of an executive type, may sometimes involve the hospital in problems arising from a threatened conflict of authority. But this only emphasizes the importance of cooperation in the hospital group, cooperation based upon knowledge of the problems and policies of the hospital, the reasons for them, and their importance. The average staff physician needs much more information as to these hospital problems than he ordinarily has had in the

Adapted from a talk presented to the Colby College Institute, Waterville, Maine, 1950.

past. I recall speaking, not so long ago, to a prominent physician in one of our Eastern cities and having him criticize the hospital as the one outstanding cause for the high cost of illness today. I was perfectly amazed to find that he had not the slightest information as to the actual cost of hospital care, the cost of nursing, the cost of food, the cost of supplies. He was still thinking in the days when hospitals could provide patient care for $4 or $5 a day. And this from a man, prominent in his profession, who should have been cognizant of all of these changes which have caused such concern to our hospitals. Can we doubt that there is misunderstanding throughout the hospital world when such a condition exists?

SHOULD JOIN HOSPITAL GROUPS

At this point I would like to suggest the advisability of encouraging, nay urging, our staff physicians to become members of our various state hospital associations. With a better understanding of all of the many problems of the hospital, such as could be made possible through such membership, and I mean active membership, much of this misunderstanding would vanish. Certainly I would urge every hospital to enlist at least the key members of the staff. I am confident that such a move would be beneficial to all concerned, hospital as well as staff.

In addition to having wider knowledge of the hospital, its workings, and its problems, shouldn't the physician have a more comprehensive understanding of what the hospital should offer him and, in turn, what he should give to the hospital? Endeavoring to answer this question I have tried to decide what I, as a physician, should, and rightfully could, expect from a hospital with which I wished to associate. What should I expect in becoming a member of a hospital staff? What would make me loyal and interested, anxious to cooperate?

First, I should expect a good staff organization, properly selected, composed of men whom I would be proud to consider as confreres, could respect and could look up to. I would expect the proper limitation of professional privileges based upon training, experience and natural ability because I would like to feel that the professional work was of the highest standard. I would expect good leadership, stemming from the governing body, the trustees. And, next, I would expect a sense of idealism permeating the whole hospital structure, an interest, primarily in the patients and their welfare, and a realization of the institution's responsibility to the community.

Then I would expect the maintenance of the highest possible standards of professional service at all times. Next, I would expect adequate diagnostic facilities. And should there be a lack of something which I felt was necessary I should like the administrator to explain to me the reasons for not having it; not to brush me off but to be receptive to some means of procuring it. And I would like the hospital to have a program of continuation education, something which is so necessary if the hospital is to fulfill its mission as a progressive institution.

Medicine is not static. It is not an exact science, and in order to practice good medicine the physician must carry on a program of continuation education, best centered in the hospital. Without it there can be little progress. There is only one way to coast and that is downhill. I would expect this program of continuation education to be based on weekly staff meetings which were teaching in character and upon clinico-pathological conferences. I should like to have the facilities of a journal club which would contribute to a better knowledge of the contemporary medical literature. I would like to find a professional staff audit because I know just how much this contributes to the advancement of professional work in the institution. I should like to find definite emphasis placed upon attendance at the various scientific society meetings. And, I would like to see some form, however humble, of clinical research being carried on in the institution. Too frequently hospitals become sterile unless some investigative work is carried on.

Finally, I should like to see, permeating the entire hospital, a spirit of encouragement for professional advancement on the part of the staff physicians, older men helping the younger members to qualify for their specialty boards or for fellowship in the American College of Physicians, or the College of Surgeons. This should include encouraging writing and publishing, for this is one of the finest means of improving the individual professional caliber of the physician. Is this too much to expect? I think not.

Now, in turn, what might this hospital rightfully expect from me as a physician on its staff? Of course, it should expect conscientious and intelligent care of my patients, without regard to whether the call comes in the evening, on Sundays, or on holidays. Illness cannot be handled on a 40 hour a week basis and good medicine cannot be practiced in that manner. An old teacher of mine once said that one's most interesting and instructive cases came on Sundays and holidays.

I would be expected to write good records—and write them on time, day by day, telling with clarity and completeness everything of importance in the medical history and hospital stay of my patients. And I should make use of consultations intelligently and freely, realizing that the pooling of professional skills is very important if we are to give our patients the best of care. Actually one important reason for the existence of the hospital is the facilitating of such pooling of skills through consultations.

USE DIAGNOSTIC FACILITIES

Then I should make intelligent use of the diagnostic facilities, using all such facilities when indicated and when they would benefit my patient, but not abusing them by using them as a substitute for mental activitiy on my part. I should be expected to give faithful attendance at the staff meetings, to come on time whenever possible, not merely when my part of the program was due, and to stay through and courteously listen to my confreres. And I would feel I would be amply repaid by so doing because I would learn things which would make me a better physician. I should realize the importance of postmortem examinations and try to obtain them, not merely for a percentage record but for what they might contribute both to medical knowledge and to my future patients. And, last, I should be expected to give faithful adherence to hospital policies, feeling that if I could not do so the hospital would be better off without me and I would probably be happier in some other institution. As a member of the staff I should render the best of service to the best of my professional ability at all times in the institution.

A good staff depends upon: proper selection, adequate leadership, a program of constant development, and a thorough understanding of hospital problems and policies. This last can be attained only through the cooperation and interest of the trustees and the administration. It would seem not only desirable but necessary. After all, a hospital is only as good as its staff.

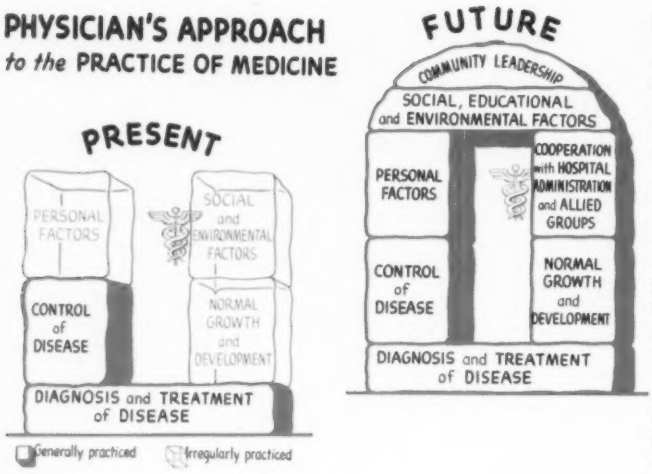


FIGURE 1

(*Continued From Page* 43.)

this before?" That educational institutions are interested in improving their programs is borne out by the fact that those responsible for medical education in this medical college were quick to take steps to correct this deficiency in medical education when it was called to their attention.

Because of the fact that physicians are going into practice in hospitals as members of the medical staff with little if any appreciation of the hospital as an organization or of the place of the physician in that organization it is little wonder that they fall down in their responsibility for staff organization and in their cooperative relationships with hospital administrators.

If physicians are to gain an appreciation of the way to become effective functioning members of a staff they must obtain an appreciation of the function of the hospital administrator and the need for close understanding between administration and medical staff. To aid them in this, the basic principles of hospital administration and medical staff organization must be included as a part of their preparation. However, it is probable that this will not be sufficient because cooperation with the hospital administrator is but one of many areas where physicians fail in their interprofessional relationships.

This failure is due apparently to a lack of the physician's appreciation of the contribution of many related health workers in the fields of both preventive and curative medicine. This may be brought out by examining the level of working relationship which exists in practice between most physicians and closely allied professional workers, including dentists, nurses, social workers and public health personnel. It is suggested that the problem of correcting the physician's attitudes toward and improving his relationships with the hospital administrators and other allied professional workers can be solved only by a broadening of the physician's basic approach to his care of patients to include the promotion of total health in addition to the care and treatment of disease. As the scope of care broadens, the physician will see the need for and welcome the assistance of allied professional workers.

The broader approach which the physician will make in the future is portrayed in figure 1, "Physician's Approach to the Practice of Medicine." When the physician develops his professional concept of patient care to the degree indicated in the area of this chart marked "Future," all factors affecting an individual's health will be given due consideration and the physician will cooperate on a high level with all related health specialists.

Figure 2, "The Health Pillars," shows the several pillars upon which total health is built and indicates that the emphasis of the physician at the present time is limited to the pillar "Freedom From Disease or Defect." It is proposed that in the future physicians will direct their efforts to the promotion of health as well as the treatment of disease and prevention of defects. Progress in this direction is seen in the development of the fields of preventive medicine, physical medicine and rehabilitation, and psychosomatic medicine.

While courses in hospital administration and organization for medical students will be beneficial, no complete solution to the problem will be arrived at until a basic change in the physician's concept of patient care and the place of allied professional specialists in contributing to patient care is effected.

The problems existing in the hospital administration field which have a bearing on hospital administrator-medical staff relationships are as great as or greater than those confronting physicians. Medicine as a profession has existed for many, many years so that it now has a substantial background with medical education and medical practice definitely defined and established. Medical licensure programs based on specified training and experience standards are in operation in every state in the Union. On the other hand, hospital administration as a profession is comparatively young with competency standards still in the formative stages.

A licensure program for hospital administrators is not in existence except in the state of Minnesota. While licensure programs have not been established except in one state, the American College of Hospital Administrators has defined standards of training and experience for hospital administrators and certifies as fellows and members those who make application and meet the standards of training and experience. It is important that the voluntary program of the American College of Hospital Administrators continue, but it is recommended also that programs be established for the registration and licensure of hospital administrators as are required of other professional groups, including physicians, dentists and nurses.

The question might be raised as to whether the work of the American College of Hospital Administrators could not be expanded and eliminate the need for licensure inasmuch as the college is already defining standards and certifying members. The answer is "no" since the American College of Hospital Administrators serves a function in the hospital administration field similar to that served by the medical

specialty boards to the medical profession in that it would certify only members in the profession who are specialists in the field. Licensure, on the other hand, would establish minimum standards that all persons serving as hospital administrators would be required to meet. Until licensure programs are established any person regardless of his qualifications, training or experience can become a hospital administrator if a board of a hospital will employ him.

If hospital administrator licensure programs are established it would appear advisable that members of the profession take the leadership in promoting such programs. Hospital administrators probably would wish to have such a program administered through a board made up of members of their own profession comparable to the pattern in operation in medicine, nursing and other fields. In establishing programs in other states it would be expected that Minnesota's experience with regulations and licensing of hospital administrators would be of value.

The development of courses in hospital administration by several of the leading universities, the approval of hospitals for hospital administrative internship and residency training and the conferring of degrees in hospital administration is an important step in establishing hospital administration on a professional basis.

One of the barriers many young hospital administrators just out of training have to pass is their own apparent attitude of hostility toward physicians and nurses. This attitude, which may be due in part to immaturity in years and experience, occurs frequently enough to raise a question as to whether this attitude is inadvertently allowed to develop during their formal preparation. Contrast with this the fine attitude of mutual respect and confidence of hospital administrators and their medical staffs which is fortunately frequently found in many hospitals today. It does appear unfortunate that so many graduates are often able to obtain employment in important hospital and administrative posts prior to a period of seasoning in the field. It would be expected that when the field becomes more stable, with demand and supply more nearly equalized, that graduates would work several years in the positions of assistant administrator in order to gain in experience, judgment and maturity under supervision and direction before assuming top administrative positions.

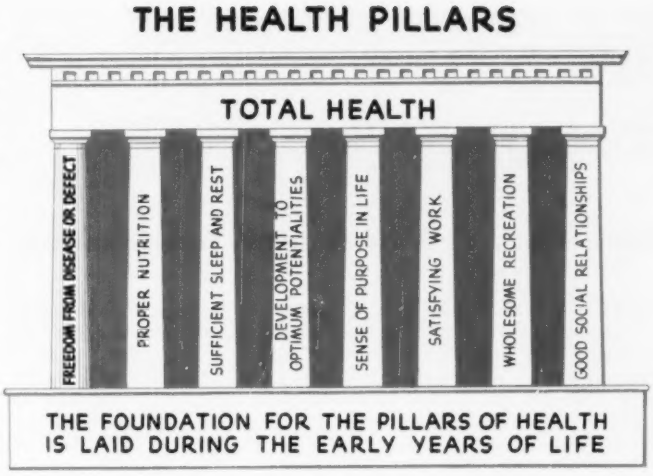


FIGURE 2

A serious deficiency found among many hospital administrators is their apparent lack of appreciation of the professional aspects of the treatment of the sick and of the elements and the contents of hospital programs necessary for the promotion of health. It is seriously doubted if students can obtain sufficient knowledge of this aspect of their work in present training programs. If they were properly prepared in this field, it would be necessary appreciably to lengthen the curriculum.

In order for a hospital administrator to establish goals, plan, coordinate and direct the hospital program, he must have a good understanding of present principles of patient care and of the trends in the various professional fields for advancing the level and concept of patient care. It is believed that this aspect of hospital administration needs to be carefully studied in regard to educational preparation and practice. In this regard, it is imperative that the function of the hospital administrator and his interrelationships with the medical and other professional staffs need to be carefully defined. Definitions alone are not enough, however, they must be recognized and accepted by physicians and other professional groups if they are to serve their purpose.

There does appear to be a recognition on the part of many hospital administrators and physicians that the relationship between hospital administrators and medical staffs is often not one of cooperation; they have an appreciation that it is essential that their relationship be one of cooperation, and they express a confidence that it can be accomplished. It is this recognition of the problem, this appreciation that it can be resolved, and this desire to have it corrected that make the possibility for future betterment in this relationship appear promising.

It does seem that there is need for the leaders in the hospital and medical fields to admit to each other that a problem exists and jointly take steps to study it and take remedial measures. The following recommendations are offered to hospital administrators and physicians and their respective associations for their consideration as steps toward the analysis and correction of faulty relationships between hospital administrators and their medical staffs:

1. As a first step it appears desirable that a commission be established representing the Council on Medical Education and Hospitals of the American Medical Association, the American College of Hospital Administrators, the American Hospital Association and the American College of Surgeons and other groups interested in the problems of group relationships and education for the purpose of making a study of the curriculums in schools of medicine and hospital administration. Curriculums in medical education should be studied to determine whether or not physicians are given a proper appreciation of

the fundamental principles of hospital administration, of medical staff organization and of the relationship of the medical staff to the hospital administrator, the governing board and the staffs of other hospital departments. The curriculums in hospital administration need to be studied in regard to information imparted about professional aspects of patient care as it is practiced, and the goals for improvement of patient care and community health programs.

Both curriculums need to be evaluated in regard to the methods used to teach the advantages of cooperative action, and the technics required for joint planning and coordination efforts.

2. The commission should consider the steps necessary to establish hospital administrators on a more secure professional footing with other professional groups. The advisability of state licensure of hospital administrators should be considered.

3. The American Hospital Association, the American Medical Association, the American College of Surgeons, and the American College of Hospital Administrators may well consider establishing a joint committee to study the problems of hospital administration-medical staff relationships in hospitals and to develop joint programs for the improvement of understanding and cooperation between physicians and hospital administrators in practice.

SHOULD HOLD JOINT MEETINGS

4. State medical societies and hospital associations need to plan certain meetings together for discussion of mutual problems. In addition, a consultant team consisting of representatives from the state medical and state hospital associations might be made available to provide consultation to hospitals that wish to improve their total administrative organization and to those that are having problems of concern to both physicians and hospital administrators. This consultation should be concerned with assisting in strengthening the administrative organization of the hospital. Leadership must be encouraged to develop within each hospital so that each institution may analyze and correct its own problems.

5. State medical societies might employ a qualified person to provide consultation to hospital medical staffs relative to improving medical staff organization and developing a plan of medical audit as a tool for the improvement of medical standards of practice and for medical education.

6. Local hospital staffs, particularly the hospital administrator and representatives of the medical staff, should jointly consider on a study basis in their individual situations how they might enlist the full participation of staff members in medical staff organization and in gaining a close functional relationship between the medical staff and hospital administrative personnel.

Three Views on State Hospital Superintendents

THE *American Journal of Psychiatry* for September 1950 contains three articles on the qualifications and duties of hospital superintendents for state psychiatric institutions. Each article views the hospital superintendent in a different light.

In the first paper, "Why State Hospital Superintendents Fail," Dr. Clifton C. Perkins points out that the hospital superintendent must maintain personal conduct that inspires confidence in the lay public. He maintains that the superintendent must act "as normally as possible." The author says that the administration of state institutions is part of state medicine, and that the individual superintendent must never lose sight of the fact that the welfare of the group of hospitals is more important than the individual superintendent.

One of the most important considerations in the care of patients in state mental institutions is kindness to the patient or, as Dr. Perkins calls it, "loving care and spiritual guidance," which he claims is just as important today as it was many years ago before new therapies came into being.

Dr. Addison M. Duval, in his article, "The Clinical Director Looks at the Hospital Superintendent," knows that the superintendent sets the atmosphere for the entire hospital and that the clinical director should know his superintendent intimately and well, but never so intimately that personal feelings rather than sound professional judgment prevail. The clinical director looks for a strong sense of personal discipline in the superintendent, one who acts with quiet deliberation, has a decisive manner, and one who believes firmly in staff organization. He must be able to fit the right person into the right job and be able to delegate responsibility so that the superintendent can deal with the broader phases of his position, such as public relations and hospital policy. The superintendent must be able to set up a personnel organization that not only will obtain the right type of people for the job, but will maintain them in these jobs insofar as the employes' health and well-being in the job are concerned, so that proper morale is maintained in the hospital. Finally, the superintendent, according to the author, should be available to the staff at all times for the discussion of hospital and personal problems when necessary, and should be happy to see his staff members move on to better positions even though it might mean a disruption of staff organization for some time.

Laura W. Fitzsimmons, R.N., in her article "What the Nurse Looks for in the Administrator," asks for a competent physician-administrator. Her contention is that business executives tend to underrate the high humanitarianism which is a symbol of good hospital care. She asks that the physician-superintendent take nursing directors into his confidence as far as nursing policies are concerned, and given the job of maintaining the nursing department and a nursing school, they should be given a certain responsibility for these positions. The author asks that the administrator inject a personal touch into his administrative duties, and while she realizes that many state institutions are large and the number of employes is great, it is gratifying to see an administrator making rounds and observing employes at work. Miss Fitzsimmons summarizes her article by saying that the nurse is willing to work under a medical administrator who is motivated only by the highest ideals and who has a progressive plan for action in which she plays a part. In the final analysis, she says, "The nurse must feel that the administrator wants and will accept nothing else than the best possible care for his patients."—I. GOTTSEGEN, *Montefiore Hospital Country Sanatorium, Bedford Hills, N.Y.*

FIRE ORDERS

CARL N. PLATOU
Administrative Intern
Northwestern Hospital
Minneapolis

CLOUDS of smoke billowed from a closet on the third floor of Northwestern Hospital. Arlene French, student nurse, discovered it a 2 p.m., and the first full-fledged hospital fire drill in Minneapolis was underway.

"She reported to Mary Musich, head nurse on the floor, who notified Vera Close, chief telephone operator.

"In rapid fire order, the hospital's carefully planned fire orders went into effect."

This was part of an article which appeared in the *Minneapolis Star* on June 15, 1950. It was the story of the "fire" at our hospital. A planned fire, which took only a few minutes to get under control, tested in those short minutes the strength and weaknesses of our fire prevention program. The testing took only a few minutes, but it took 12 months to prepare for such an event; 12 months of discussions, lectures, demonstrations, movies, tours and planning conferences. We spent this time and energy because the saving of lives and property during the short critical moments of fire is a prime duty to our patients and to the community which supports the hospital.

The question we faced was: how best to educate and equip our people to meet such a crisis.

We decided to use a pattern which had previously proved successful to us on problems involving the entire hospital: a group of persons representing the departments concerned having an hour meeting once every two weeks around a conference table to discuss the best ways of solving a common problem. In these meetings were the assistant administrator, the chief engineer, a nursing arts instructor, one of our dietitians, the housekeeper, the administrative intern, and people from outside the hospital who added to our limited information, such as a safety engineer from our insurance carrier, and, occasionally, the assistant chief or another member of the city fire prevention bureau. From these meetings the hospital's fire evacuation and fire prevention program was evolved.

Close cooperation with the Minneapolis fire department. This was accomplished effectively and beneficially for the hospital when the assistant chief of the fire prevention bureau attended the meetings. The chief brought his long experience and information to guide us toward improvement of the fire prevention phase of our program. His contribution to the preventive program acquainted us with the physical needs of the hospital. Some of the needs he stressed were:

1. Automatic door closers on the fireproof doors opening into the fire tower.
2. Safety cans for gas or ether.
3. Only 15 ampere fuses in all fuse boxes.
4. Special fire blankets in the x-ray department.
5. Fire extinguishers in the x-ray department plainly marked, "Do Not Use on Electric Fire" (if they contain soda and acid).

Selection of personnel to serve as a hospital fire brigade. The fire brigade is made up of the men employes in the hospital, *i.e.* the orderlies, maintenance men and firemen, and those in the housekeeping department. Each man is instructed as to his specific responsibilities, where his station is, what his duties are, and what the lines of communication are. They are all trained by the fire department to man fire-fighting equipment.

The fire brigade is a functioning unit in which each man is assigned to provide "stop-gap" aid until the fire department arrives. Four men take the fire-fighting cart with its various extinguishers, ropes, buckets of sand, and an axe to the scene of the fire; four other men also go to the fire to use whatever equipment is permanently placed in the area, and a number are assigned to the control center to be dispatched "on call." Therefore, in effect, a fire department is always present within the hospital.

All personnel receives copies of our "Fire Orders." This booklet incorporates all the information pertaining to fighting a fire at Northwestern Hospital. The details covered include the following:

1. General rules for all floors.
2. Definitions of what our control center is.
3. Special assignments.
4. What to do when you first hear of the fire: (a) when you are away from your working area, (b) when you are in your working area.
5. Movement of patients and employes.

"Minneapolis Star" Photograph

An employe, representing a patient, is lowered from window.

All present employes are oriented and trained in this program and participated in our "Fire Drill."

1. They are trained in the use of fire extinguishing equipment. The nursing arts instructors give talks to the personnel on the floors about the equipment. Members of the fire department's prevention bureau give demonstrations on handling the equipment.

2. It is planned that all personnel employed in the future will be oriented by the fire drills and given the same training.

3. All employes know the location of fire-fighting equipment in their area. It is a responsibility of the supervisors to acquaint the personnel with the location of the fire equipment.

4. All employes know the location of the fire doors, which are closed by heat stimulating the fusible links. These are overhanging doors in the hospital corridors. The employes know which wings can be closed off by the automatic dropping of the doors.

5. All personnel is required to know the location of exits to facilitate the flow of traffic.

6. Located at each nursing station is pertinent information for periodic review or instant reference.

7. All employes know the fire alarm: *all numbers* flashing on the visual call system and an alarm bell in

nurses' residence and basement and engineer's quarters.

One year after the first planning conference, the stage was set for a fire drill.

The location and "cause" of the fire (a CO_2 extinguisher manned by a member of the fire prevention bureau) were predetermined; employes were told the date and time of the drill; patients had notices on their breakfast and lunch trays notifying them a fire drill was scheduled and not to be alarmed; the fire department came to the hospital to evacuate an employe representing a patient; visitors in the lobby were told about the drill and held there until the fire drill was completed. The elevators in the lobby were held for the use of the fire department. So the drill began. Immediately upon receiving the report of the fire, the switchboard operators:

1. Notified the fire department.
2. Turned on the hospital fire alarm.
3. Notified the administrator.

All employes swung into action. The fire brigade went quickly to the scene of the fire. The chief engineer took command of fighting the fire until the fire department arrived. The administrator stationed himself at the control center at the switchboard, getting information about the situation and relaying orders. The control center was the hub. It gave direction and coordination to activities.

Nurses on the floor shut off the ventilating system, closed windows and doors, reassured patients and visitors.

Employes not assigned to specific duties assembled in the dining room "dispatch center" and from there were assigned to areas as needed by the control center.

All this had taken two minutes. Within three and a half minutes the fire department had arrived and an employe representing a patient was lowered out of a window. Two other employes also acting as patients were taken from the fire area on stretcher carts. At 2:15 p.m. the fire chief requested the control center to report "all clear" to the nursing stations, dispatch center, and public areas. This ended our first fire drill.

The drill tested the year's planning and action. We think our efforts were well spent and rewarded with success. From this experience we have gained confidence that patients now have a greater security from the hazards of fire while they are at Northwestern.

GOOD SUPERVISION *is the answer*

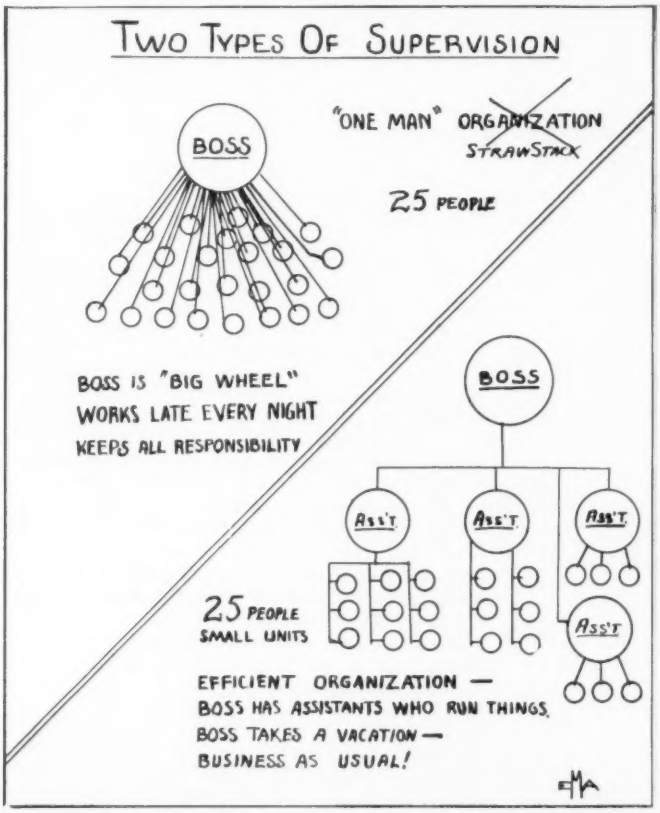
to developing favorable group attitudes

EDMUND MOTTERSHEAD
Chicago

THE supervisor who has charge of the activities of a group of men actually has two problems in dealing with them: the problem of his individual relationship with each man, and the second problem of his overall relationship with the group as a unit.

There is a variety of factors, such as common tasks, eating together, the plant bowling team, having similar hours of work, being of similar nationalities, having families, and so on, which rapidly tend to weld a group of workers in a department into a unit. And the problem of developing a desirable "group" attitude is slightly different from that of dealing with one individual.

Before going into the specific technics of creating and maintaining group attitudes, just what is a "favorable" group attitude? Basically, management wants loyalty, efficient production, doing the job right, doing it rapidly enough to be economical, doing it safely, doing it without waste of materials and breakage of tools and equipment, doing it at a sufficiently high level of quality. Along with this productivity, management wants good shop discipline, wants workers to come to work on time and quit at quitting time, hopes that workers will look forward to staying on the job for many years, wants some sign of interest in improvements, looks for suggestions, and in other ways would like workers to evidence a feeling of personal pride and interest in their work and in the company.



Inasmuch as the supervisor represents management directly to his workers, his actions and policies, what he says and the way he says it, his character, integrity and habitual conduct have a direct influence on the thinking and emotional reaction of his group. Much has been written about the department being a "team" with the supervisor the captain of the team; any "team" reacts *as a whole* to its captain's leadership, good or bad.

There are two types of supervision, just as there are two types of leadership: there is the "boss" who is sincere, hard working, but fears to delegate any authority or responsibility to anyone else and consequently handles many details himself that someone else should handle for him; his is the "one-man organization." On the other hand, there is the department head who knows that the secret of good departmental administration lies in breaking down the supervisory load into small units; this man has assistants who handle the details concerning various operations and smaller segments of his department, so that he can go fishing without worrying whether the place will fold up in his absence.

All people, whether workers or managers, are motivated by two fundamental urges: the desire for gain, and the desire for recognition. On the one hand, they want profits, increased income, economic security, reduced taxes, higher wages, bonuses, cash in the bank; and on the other hand, they want to feel important, from the standpoint of not only serving a useful purpose in life, but also of gaining recognition in discharging that function.

SUPERVISOR'S PERSONAL CHECK-UP CHART

Indicate with (X) your usual conduct in each situation described below:

	ALWAYS	USUALLY	SELDOM
1. Do I know all the rules and regulations that are necessary to me?			
2. Do I obey the rules and regulations myself?			
3. Do I avoid any show of favoritism or partiality among the men?			
4. Do I consider the workers as individuals?			
5. Do I give them full credit for an idea or a suggestion or for good work?			
6. Do I refrain from holding grudges?			
7. Am I fair in my dealings with every man?			
8. Do I give help to both old and new workers, willingly, when they need it?			
9. Do I try to anticipate their problems and possible gripes?			
10. Is my heart obviously in my job?			
11. Do I reprimand only when necessary?			
12. Do I give a man a chance to make good instead of harping on the same thing over and over again?			
13. Do I make most decisions for myself instead of running upstairs to the boss?			
14. Am I constantly alert for short cuts that will help my men and the plant?			
15. Am I aware of costs, and am I trying to keep them down?			
16. Do I have the right people on the right jobs in my department?			
17. Do I spread the "dirty work" around evenly?			
18. Do I refuse to take any legalized graft (cigars, canned goods, liquor)?			
19. Do I conduct myself in a manner which commands respect at all times?			
20. Do I practice what I preach?			
21. Do I get all the facts in a situation before reaching a decision?			
22. Do I back up my men when they are in trouble?			
23. Do I think of the effect of my decisions on other people and on other departments?			
24. Do I avoid excesses, such as heavy drinking, profanity?			
25. Do I try to advance myself by study, reading?			
26. Do I accept criticism and help readily?			
27. Do I listen sympathetically to a worker who has a problem?			
28. Do I cooperate willingly with other supervisors?			
29. Do I get along with the personnel department?			
30. Am I friendly and cheerful?			
31. Do I try to correct mistakes promptly?			
32. Am I calm, not likely to fly off the handle?			
33. Do I think a problem through and not jump to conclusions too rapidly?			
34. Am I constantly alert for the safety and health of my workers?			
35. Am I willing to pitch in and help when the need arises?			
36. Am I free from burdensome paper work and red tape?			
37. Do I report to the front office when I should instead of covering up for an offender?			
38. Am I willing to stay late to clean up important work without kicking about it?			
39. Am I willing to admit my own mistakes?			
40. Do I accurately represent management to my men?			

Take 3 points credit for each ALWAYS. Take 2 points for each USUALLY. Deduct 3 points for each SELDOM. Total your score.

Under 50—needs much improvement
50-60—not so hot
60-70—just getting by
70-80—fair
80-90—good
90-100—unusual
100-110—exceptionally good
110-up—too good to be true.

James F. Lincoln has written: "We are approaching the end of technical development as a sole reliance in manufacturing methods. The individual worker, *if he wishes sufficiently to do so*, can carry production to heights possible in no other way. American industry now must go to that much greater source of manufacturing progress on those inherent undeveloped capabilities latent in every human being." Management can find workers who will take a proprietary interest in the plant when intelligent selfishness is used to install an equitable and effective incentive system. Giving workers a real, workable and understandable opportunity to satisfy their desire for gain and security will give them a vital, personal interest in doing those things which go to make up a "favorable attitude."

In giving the workers a sense of importance, the supervisor can do much by his own attitude and habitual actions to convince them of the importance and usefulness of their jobs. Individual recognition for good performance must be tempered by a policy of showing no favoritism. Whiting Williams says that he can never start an argument among workers by asking: "Which would you rather have, a punk job with a good supervisor . . . or a good job with a poor supervisor?" The answer is always instantaneously in favor of the "good supervisor."

The habitual attitude and actions of a supervisor are so important in developing group attitudes because of a basic psychological force called empathy. *Empathy* is akin to sympathy. It is the strange electrical current running between people in a group which gives them a group emotional reaction to their boss, leader, supervisor. They react to your manner and attitude even more than to what you say.

People have an instinctive sense of the "rightness" of things. Suppose you were looking at an old-fashioned scale or balance with two pans holding objects of different sizes. The pan holding the larger object, apparently heavier, is higher than the other. It looks wrong. You *feel* it is wrong.

In the same fashion, if you are lackadaisical in manner, slouching, appear careless and indifferent, your workers get the feeling that something is wrong with you, that you, too, are indifferent and careless. If at the same time you are trying to say something that is positive and enthusiastic, they feel uneasy, for your attitude and actions do not agree with what you are saying.

You show action and get reaction. Try it on yourself. Professor Dewey tells us that our "muscle sets" to a large extent determine our psychological feelings. Slouch down in your chair, and your brain slows down. Sit up erectly as though you were about to jump up, and your mind becomes more alert. Scowl and snarl with your face, and pretty soon you are in an unpleasant frame of mind. Put a smile on your face, and in a short time you feel happier. If you habitually bluster and speak harshly, your listeners will react accordingly. The famous horse trainer, Rainey, reports that he has known one angry word to raise the pulse beat of a horse as much as 10 beats per minute. How much more sensitive are human beings, and how much more deeply are they affected by your unconscious manner, attitude, and by your outward appearances and actions!

In trying to develop a favorable attitude from your departmental group as a whole, remember that "what you are speaks louder than what you say." Each man is an individual, different in background and problems and thoughts from all other individuals; yet he has in common many of their beliefs and ideals and reactions, and it is this thread of common-ness which welds your individual workers into a group which demands special attention from you. First determine what group attitudes you want to maintain; then analyze your own conduct to see just what you need to do to develop the desired group attitude. The accompanying personal check-up chart may aid you in this step.

COAL FOR THE POOR

ON THIS chilly day we might talk about the Brewer Fuel Fund. It's an interesting story, with some strange angles to it.

Charles Brewer was an Englishman who came to Pittsburgh as a young man in 1814. He had some money, and set himself up in the dry goods business at Fifth Ave. and Market St.

He joined Old Trinity, married a local belle and prospered. He built a great mansion on Water Lane, Allegheny (now Western Ave., Pittsburgh, and the mansion still is there, occupied by a beverage company).

Always a kindly man, Charles Brewer became a philanthropist in his late years. When he died in 1860 his will showed how varied his charitable interests had been.

Always interested in the plight of the slave (his mansion was said to be a stop on the "Underground Railroad"), Mr. Brewer left money to improve the lot of Negroes in this country and help those who wanted to go back to Africa. He left a tidy sum to an Indian mission in Minnesota. And he left money to more ordinary causes.

But about the Fuel Fund! Mr. Brewer gave it a lump sum of $10,000—which was quite a lump in those days—and said it was "for supplying with fuel the destitute and worthy poor of Pittsburgh and vicinity."

Apparently he had been touched by the suffering of the poor in winter, and resolved that they should at least be warm. There was no state relief in those days, of course, and there were few private charities.

Mr. Brewer thought the West Penn Hospital would have contact with many "destitute and worthy poor," so he left the fund in its care. For nearly half a century the hospital doled out coal by the bushel and the ton.

In 1909 it convinced Orphans' Court that distributing coal wasn't part of the work of a hospital, and turned the fund over to the Commonwealth Trust Co. In 1946 Commonwealth turned over the job of distributing the income to the Pittsburgh Foundation, which was organized to handle a number of small funds (and from which I got this story).

In spending the money, the Foundation has 15 selected charitable agencies which recommend families that are in need of coal or help on their fuel bills.

How much would be left of Mr. Brewer's $10,000 after all these years? Well, when the estate finally was settled, it turned out to be considerably more than $10,000, and wise investment increased it through the years to a present $75,000.

Only the income from this money has been used to buy fuel. In 87 years it has bought over a quarter of a million dollars' worth of coal to keep poor families warm.—GILBERT LOVE. (*Condensed from "Pittsburgh Press."*)

NEW AIR for the NEWBORN

newly developed "breathing incubator" is highly effective in resuscitating asphyxiated infants

A REMARKABLE "breathing incubator" developed by Dr. Allan Bloxsom of Houston, Tex., is proving unusually effective in resuscitating asphyxiated new-born infants in St. Joseph's Hospital and three other Houston institutions.

The air lock, as it is called by its inventor, has to date been used for more than 100 asphyxiated infants at St. Joseph's Hospital. The immediate benefit to these infants is that the mortality rate in the hospital has been reduced from 2.50 to 1.95 per cent, a reduction of approximately 25 per cent. The future value of the lock to a large number of infants is hard to determine, but without doubt a great number of them will be better equipped mentally because of prompt and quick oxygenation of the central nervous system.

By expansion of gases, the lock expels fluids and secretions from the pulmonary tree so that no suction by tracheal catheter or bronchoscopic examination is necessary. Approximately one out of five infants will bring up a considerable amount of pulmonary fluids and secretion when placed in the lock.

The lock is designed to maintain heat and humidity and to produce a cycling of pressure and timing of the cycling similar to that in the second stage of labor. No handling is required for the infant nor is any suction necessary.

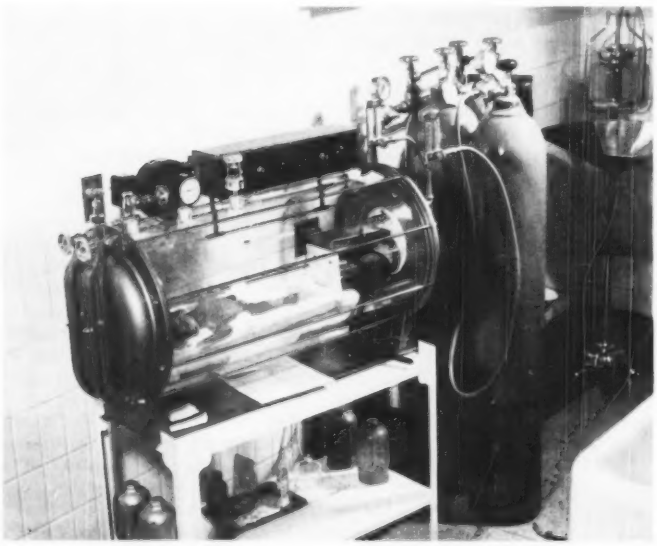
The infant is left in the lock until his respirations become established, and then he is kept under positive pressure of 2 pounds. His hands and feet are observed carefully for any sign of cyanosis and if none occurs after an interval of four hours the pressure is reduced to 1 pound for one hour and the child is taken from the lock and placed in an incubator and given oxygen at 8 liters per minute.

A few of the larger infants establish their respirations almost immediately and may be taken from the lock after an hour or two. Some of the very small premature infants have had to remain in the lock for as long as 10 days.

The air flow is set at 8 liters per minute, and the oxygen at 8 liters, which provides the infant with 60 per cent oxygen concentration. The time of cycling to increase the pressure from 1 to 3 pounds is 30 seconds and the time of discharge to reduce the pressure from 3 to 1 pound is 15 seconds.

The air lock is the only practical or theoretical machine devised to oxygenate the asphyxiated infant properly and to expel fluids and secretions from the pulmonary tree by the expansion of gases. It will not do the impossible of keeping alive infants who have had tentorial tears, cerebral hemorrhage, congenital heart disease, or other conditions incompatible with life, nor will it save extremely immature premature infants. However, one infant weighing 1 pound 14 ounces and of 26 weeks of gestation has been salvaged by keeping it in the lock for a week's time.

It has been found that the lock is used best when the asphyxiated infant is immediately placed in it before a number of resuscitative measures are tried. Several infants have been placed in the lock without their respirations being started and all did remarkably well, the respirations being started within a minute or two.



The infant is placed in the tube-like oxygen tank in which pressures are automatically regulated to simulate those of the body. The infant can be watched through cylindrical glass sides.

HOSPITALS *Versus* the ATOM BOMB

I—CIVIL DEFENSE

LT. COL. J. T. RICHARDS, M.S.C.

Director
Course in Hospital Administration
Medical Field Service School
Brooke Army Medical Center
Fort Sam Houston, Tex.

NO ONE mind in America today is capable of foreseeing and offering the solution for all of the problems that would arise from an atomic attack on our country. Planning for such an event is a task that requires the best thoughts of all of us. The following comments are not purported to represent a complete treatment of the subject. They do represent, however, a review of most of the problems, together with an approach to their solution. Since resources and capabilities will vary among communities, it is obvious that these will dictate some deviations in plans from one area to another. Hence, no one blueprint can be provided by the federal or the state governments that a given community can follow in detail.

HAVE WAITED TOO LONG

Those of us residing in a given community have already, in many instances, waited too long to take necessary action *at our level* (that can only be implemented by plans of the state and federal government). Our consideration here is not intended to embrace civil defense in either active or passive forms except as they may affect the medical care and hospitalization efforts for mass casualties. Individual and collective measures for protection against blast, burn and radiation effects are essential. They must, however, be a public education measure, designed on a large scale, that will acquaint every citizen with the actions he must take and when he must take them. This educative process is ultimately a community function. It is designed to reduce casualties. Let us here concern ourselves with what and how we must prepare for those casualties we know we shall have. This should be of primary concern to those in the medical care and hospitalization field, yet in some instances mayors and county judges have not included hospital administrators on their planning committees. The report "United States Civil Defense" released by the National Security Resources Board points out the legal responsibility for planning at the local level. This rests with the mayor or the city manager of the municipality and the county judge for areas outside the corporate city limits.

Even if you, the administrator of a hospital, have been overlooked in planning committees, you still have a responsibility to the people you serve. This consists of an analysis of the resources available to your hospital for casualty care and the reporting of these resources to the appropriate official. We shall consider the approach to this analysis later.

Let us now indulge in a few abstract evaluations. We all recognize that we are vulnerable to atomic attack in all of our major industrial areas. The extent to which we are vulnerable will lessen in direct relation to the adequacy of our radar perception devices and our interceptor capabilities. Most military planners concede that these devices will never reach 100 per cent effectiveness. Else why should we plan civil defense or disaster relief at all? Granting, then, this vulnerability, let us hazard some gross "guesstimates" of possible casualty figures. These, of course, would vary as with several factors, such as the day of the week and the time of day. (Pearl Harbor was on Sunday when the maximum number of ships could be anticipated to be in port for shore leaves.) How many bombers would get through? What would the bomb load be? How much more powerful would today's bomb be than those of Hiroshima and Nagasaki? How much more resistant are our steel and concrete structures than those of the Japanese cities? Would such an attack as we are considering concentrate on two or three cities or would an enemy spread its destruction as widely as possible between cities? As we consider these ponderables we recognize Kipling's truth that "you never can tell till you've tried 'em, and then you're like to be wrong."

We now realize that neither our crystal ball nor even our best estimates are likely to be close enough to reality. Then we must adopt, for planning purposes, an *assumed casualty figure.* What should it be? Let us begin with the rather modest estimate of 20 per cent casualties for a mid-day blast. Then in a city of 500,000 we should expect 100,000 casualties! True, these would need medical care of varying degrees and a fair assumption of hospital cases would be 40 per cent. But where would we find 40,000 hospital beds within a reasonable radius of a target city? The obvious conclusion is that regardless of fallacious planning assumptions, we are not likely to have enough hospital beds for even a limited atomic attack *unless we think now in terms of maximum potentials.*

The space available in this publication would not permit detailed consideration of all of the aspects of disaster relief planning. Hence, let us isolate those problems that should fall to the lot of the hospital administrator in planning and devote most of our considerations to them.

PHYSICAL RESOURCES

Every community in America must be prepared to absorb casualties to the maximum extent of its resources. Those cities within a hundred-mile radius of an assumed target city would of course receive the initial shock. Ultimately, however, each community must stand prepared either to receive casualties or to supply personnel, supplies and equipment to be moved to support a relief effort elsewhere.

The plan for a given community would be altered by a review of its particular rôle in this respect.

Our first consideration in an analysis of a community potential is in avail-

able hospital beds. Now is the time to consider patient's bed cards in terms of green for those who can be discharged at no hazard; a pink card to indicate the patient who could be cared for at home, and finally, a red card for the nontransportable.

Such a procedure would reveal available beds. Next, how many beds, real or improvised, can be placed in halls, corridors and in existent wards and rooms by reduction of floor space to 70 square feet per bed? Following these actions, space analysis calls for evaluation of adjacent buildings or areas where tentage could be pitched if it were available or could be provided. The season of the year will be a factor because of space heating under winter conditions. If you are wondering where the beds will come from to occupy all of this space, now is the time to face reality. Many casualties will undoubtedly not have a bed. But canvas cots or an ordinary house door on a saw horse will suffice in dire need. Improvisation will be the greatest asset the administrator can have.

The next inventory, after space, should be that of equipment, not only for the beds that have already been mentioned, but also for the minimal items for nursing care, such as basins, hot water bottles, thermometers, syringes, and, above all, any available supplemental equipment to permit expansion of operating room facilities.

Supplies are next for inventory. Citizens may be called upon to volunteer extra bed clothes or other items of need. Each item of supply should have substituted items envisioned. Thus, ether apparatus may have to give way to the mask and can of ether. Catgut sutures may give way to silk sutures and finally to sterilized silk sewing thread. One antiseptic will be exhausted and another will be used instead. Such is the type of thinking that must prevail. It was contemplated to propose here a list of medical supplies essential to emergency care. The list is prohibitive in length. However, such a list will be supplied or can be made available by governmental agencies if hospitals and medical staffs have not already worked up their own. So much for a consideration of inventory of physical resources available in the given community. Logically the personnel problem falls next.

PERSONNEL

Hospital personnel requirements are only a part of the total requirement. Each community must be inventoried to determine its total personnel potential. Each citizen not subject to military service should be called upon to complete a questionnaire that would provide certain minimal information. Name, address, sex, age, type of work performed, and special training or avocations not used in job situation should be obtained. This sounds like a tremendous task and it is. Civic organizations can and should provide volunteer personnel for the task.

Once the inventory is made, requirements need to be established. This calls for organization. Community organizations may differ in detail, but certain principles of organization must be followed. Every major function must be fixed as the responsibility of an individual. The proposed organization is believed to provide a structure within which all responsibilities can be fixed. Who should occupy the positions in the community will depend on who is available and is best qualified.

The greatest obstacle presently encountered in some plans is that of political ambition on the part of selfish individuals. The success of any plan designed to integrate and coordinate the efforts of an entire community will be in direct proportion to the extent to which this can be eliminated. If the mayor or city manager chooses to retain the position of Director of Civil Defense as proposed here, then he will need a full-time deputy to keep the planning and training up to date and dynamic. The advisory committee should be representative of all civic, social, professional and religious organizations in the community.

Assignment of personnel to units or positions in the chart should be determined by several factors. First, consistent with capacity for the assignment, persons should be assigned on a geographical basis. John Doe and Jim Smith should not be assigned to the same unit if they live on opposite sides of town. Evening training sessions would then become inconvenient. Also, employment as a coordinated team would be facilitated by their proximity to each other at time of need. Industrial and business organizations whose welfare and productive life are also at stake may well devote one or two hours weekly to training of individuals or units.

A city map must be marked off into zones that are well defined by perimeter streets, highways, railroads or other natural boundaries. This zonal area of the urban or target city can then anticipate support from a suburban or satellite city if planners will integrate their plans. No community can be independent of its sister community or its state plan. We have sketchily mentioned personnel, organization and resources inventories. Let us now give thought, as space will permit, to some of the miscellaneous factors that need to be considered in a given plan.

MISCELLANEOUS FACTORS

The following factors concerning disaster planning have at one time or another been overlooked in some plans. Some will be identified as functions chargeable to units in the organization. Others are not identified as such and must be made the specific responsibility of someone. For example, the problems of erection and location of signs, prepared and stored in advance, could well be charged as a responsibility of the law enforcement service unit. Thus the chief of police would have a predetermined knowledge of the location of traffic routes, aid stations, assembly points and hospitals and could best ensure location of signs.

In addition to signs, the following points are of concern to the hospital either directly or indirectly so that the administrator must acquaint himself with them.

1. The method of invoking the plan must be preconceived. A system of notifying key officers of the plan is essential. Chain telephoning is expeditious if the telephones are operable. The hospital switchboard operator should maintain a card file of the key members. They, in turn, must notify their team workers. When telephones are knocked out, then a messenger system should be foreseen.

2. Alternate officers for all key positions should be envisioned.

3. Although it is not a hospital responsibility, the system of tagging of casualties should be planned. When the hospital receives casualties, they need identification (as may be possible—at least location where found) and an indication of medication received.

4. Patient sorting at the disaster site and again *outside* the hospital proper should screen out those patients for whom hospital beds are not essential. Home care should be predetermined for many casualties for whom hospital beds are not necessary or avail-

able. An admitting ward may well be utilized for this purpose.

5. Admission teams to go to the proper service for effecting admission records on emergency cases would be necessary.

6. Whole blood and blood substitutes are of such significance as to warrant separate planning. Radiation casualties are determined to comprise only about 15 per cent of the total. Medical authorities are now studying this problem. Pretyping of individuals of the community is indicated to expedite access to whole blood sources. Comments have been made concerning the tatooing of the blood type in the left axilla region. It is understood that this is a popular activity in Chicago and certainly has its favorable implications. Possibly the hospital should add a tatoo technician to its laboratory service. Silly? We think not.

7. Police and traffic control at the hospital must be provided. Those concerned about relatives and loved ones should not be permitted inside the hospital to impede the activities there.

8. Fire control is important at the hospital, too. Burning embers resulting from atomic blast will cause fires in widespread areas. All firemen must not be rushed to the blast area and overlook outlying areas.

9. Transportation by whatever means is available calls for evaluation of conversion and capacities of various types of railway and highway vehicles. Transportation facilities from the satellite city must be moved toward the blast area. The hospital must have some means of informing the authorities at the damage area how many additional patients can be taken at a given time. Returning vehicles provide a means.

10. General assembly points for uninjured persons must be designated so that a pool of available help is organized. The hospital must be acquainted with their locations.

11. There will undoubtedly be mental patients resulting from an atomic attack, *i.e.* the hysterical and the apathetic. The number of these will be minimized by education and by giving everyone possible a job to do. This should not initially be a hospital problem unless the patient is also a blast, burn or radiation casualty. The physically uninjured who become psychiatric casualties are problems that challenge the foresight and preparation of that profession.

12. Advocacy of fixed aid stations is believed to be short-sighted. They must be mobile so that they can be placed at any point suitable to the circumstances. Preliminary evaluation should be made of possible sites, but certainly there can be no assurance that a particular site will be tenable. First-aid teams should not receive primary consideration to the extent that the hospital is understaffed when casualties begin to arrive there. This was true in at least one major disaster.

13. Casualty collecting points where patients will be accumulated from several aid stations may be of advantage under certain conditions. Serious cases identified at the aid station should, however, by-pass such a collecting point. Such a collecting point should be adjacent to traffic routes that will permit minimum use and loss of effectiveness of patient transportation.

14. Evacuation is the term used to describe the patient sorting and transportation of casualties. Each has already been touched upon.

15. The hospital must not overlook provision of emergency morgue facilities for the DOA cases and those expiring in the hospital.

16. Identification data must be accumulated on those not readily identified. Photographs, dental and physical descriptions, description of attire, and the place where found must be reported.

17. Information desks must be moved out of the hospital proper and arrangements made to centralize patient information there. Press representatives could be employed to provide data on patients and their conditions. Patient visits must be withheld until operationally feasible.

18. The clergy and its rôle are important at the hospital. The clergyman of each faith should train church members in spiritual and religious rites appropriate to the circumstance.

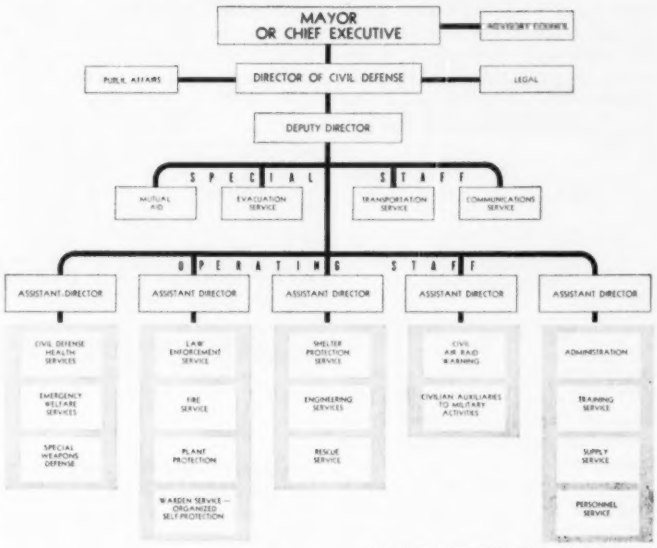
19. Many people have developed an exaggerated apprehension of the effects of radiation. This is an area of public education where the hospital administrator and the medical staff must do their part. The technical aspects of this are left to authorities in this field and the published works that they have produced.

20. Preliminary community immunizations as a public health measure should be accomplished in all communities.

21. It is obvious to any thinking person that alternate water, power and communications facilities are essential to the hospital in the target area. Sanitation measures including sewage disposal in a stricken area are also of

SUGGESTED MODEL

LOCAL ORGANIZATION OF CIVIL DEFENSE



Reproduced from "United States Civil Defense."

extreme importance. One needs but to have seen the insect and rodent population of blasted areas to realize how exaggerated the public health problem becomes. But there are qualified individuals in the person of city, county, state and federal public health officials whose responsibilities, actions and guidance here are available.

The job that lies ahead is too great for us individually but never let us admit that it is too big collectively! Religious, fraternal, racial, political or social barriers should not bar our unity in this cause. Lip service to this unified effort, belied by our actions, is tantamount to admitting that America will never retain its world position because of internal selfish interests. If that were the case, we would save much in terms of lives and economic wealth by submitting to world domination by others now. And heaven forbid that this should happen.

II—ARCHITECTURE

ISADORE ROSENFIELD
Architect-Hospital Consultant
New York City

WHEN a new and unfamiliar problem presents itself the first solutions are likely to be extreme in one way or another, but eventually things simmer down to something sensible.

In our present situation it is vitally important to review critically some of the measures which have been suggested for safeguarding hospital structures and their human content against possible atomic blasts.

Before examining the solutions which have been proposed let us consider what the principal effects of atomic blasts are.[1]

Mechanical: Injuries resulting from flying debris. Flying debris also implies destruction of buildings.

Heat: Flash and fire resulting in injuries to persons and destruction of property.

Radiation: Injuries caused by release of dangerous rays. The same radiation would render the building itself contaminated so that it becomes a secondary source of radiation.

My file shows a hospital planned as far back as 1947 which included an extensive duplication underground of the above-ground facilities. I suspect this was merely promotional dramatization of the problem rather than a sober proposal for a solution, because even if an atom bomb attack were not a surprise, it is doubtful whether it would be possible to evacuate bedridden patients to underground quarters between the alarm signal and the explosion.

However, the instinct for self-preservation is not to be taken lightly. If duplicating underground essential above-ground facilities were the only way possible, then such underground burrowing would be justified if it could be realized regardless of effort and cost. Going underground would meet almost ideally the three effects of an atomic blast for hospitals and for other kinds of activities, but it would appear that there are more sensible solutions to the problem insofar as hospitals are concerned.

Another solution that has been suggested is to continue to build hospitals above the ground, but to design them to minimize if not to resist completely the effects of an atom bomb blast.

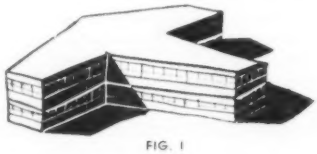


FIG. 1

The following are some of the technics that have been suggested.

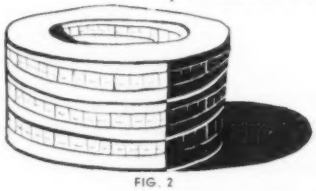


FIG. 2

Streamlining the building in such a manner as to cause the shock waves to slip off the building rather than to hit face on. In this connection a suggestion was made that, inasmuch as a modern hospital building is frequently formed like a T, it should be modified to take the shape shown in figure 1. This is an erroneous idea for the following reasons: Even if the blast came exactly from the direction in which the head of the T points, it must be remembered that an explosion blast which pushes the air out causes a vacuum behind the pushed-out air; consequently, within a few seconds there is a counter pull almost as violent as the original push. This suggests that a building would have to be streamlined in two opposite directions. But this, too, is ineffective because we have no way of knowing the direction from which the blast may come. Since it may come from any lateral direction it suggests that a building ought to be cylindrical in form, as in figure 2.

This shape is also unsatisfactory because the history of the atom bomb in Japan shows that the second bomb, which was weaker than the first but was activated high above the target, was much more deadly than the first bomb, which was exploded at the earth's surface. The experience with underwater and above-water naval experiments are said to parallel the land experience. Now, then, since the blast may not necessarily be horizontal, but may vary from horizon to zenith in any vertical plane, a building would have to assume a

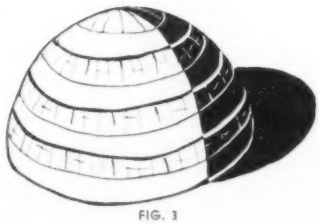


FIG. 3

[1] Special Issue on Civil Defense Against Atomic Attack. Bulletin of the Atomic Scientists, August-September 1950, p. 242.

hemispherical form to withstand atomic blast insofar as pure shape is concerned. (Fig. 3.)

Since shaping the hospital building as suggested is impractical, though possible, this idea should be discarded if a better approach can be found.

It should be discarded for still another reason. Photographs of Hiroshima and Nagasaki show that modern reinforced concrete buildings did not topple even though they stood in the area of major destruction. Exterior walls and windows and interior partitions were more or less blown out and with them the human content, but the frame—the columns and floors—remained intact. This teaches us that the frames of modern buildings, if properly designed, can withstand an atomic explosion.

It has been observed, however, that because Japan is an earthquake country, its "framed" buildings have been designed to withstand earth tremors, and that this accounts for their stability. "Earthquake design" is not anything new to American architects and engineers, and if any buildings are designed these days which because of their location or content are likely to become targets, then it would be reasonable to design them along principles employed for withstanding hurricanes and earthquakes. Such precautions do not in themselves present serious problems of cost and could, therefore, be considered as reasonable where indicated.

It should be observed, however, that blastproofing involves more than the frame. Brick walls or any other enclosures would also have to be reinforced in accordance with known principles. Windows also would have to be extra strong and the glass itself presents a special problem. It is pertinent to state, however, that at this time it is not possible to procure and install blastproof glass except at considerable expense.

Actually, all of the foregoing is idle speculation because we cannot rebuild or in any major way safeguard existing hospitals standing in possible target areas. About the only thing that could be done with them would be to install some kind of shatterproof glass which would be effective only if the hospital were sufficiently remote from the target. As was pointed out, a hospital which is not properly designed simply could not survive within "ground zero."

Dr. Marcus Kogel, Commissioner of Hospitals of New York City, quotes a description of what happened at Hiroshima as follows:[2] "Two large hospitals of reinforced concrete construction were located 4900 feet from ground zero. The basic structures remained erect but there was such severe interior damage that neither was able to resume operation as a hospital for some time and the casualty rate was approximately 90 per cent, due primarily to flying plaster, flying glass and fire. . . . Fire-fighting and rescue units were equally stripped of men and equipment. . . ."

What this quotation means is that "there is no hiding place" because, to quote again from the U.S. Strategic Bombing Survey on Effects of Atomic Bombs on Hiroshima and Nagasaki, "the large majority of people within 3000 feet of ground zero were killed immediately. Within a radius of about 7000 feet almost every Japanese house collapsed. Beyond this range and up to 15,000 to 20,000 feet many of them collapsed and others received serious structural damage."

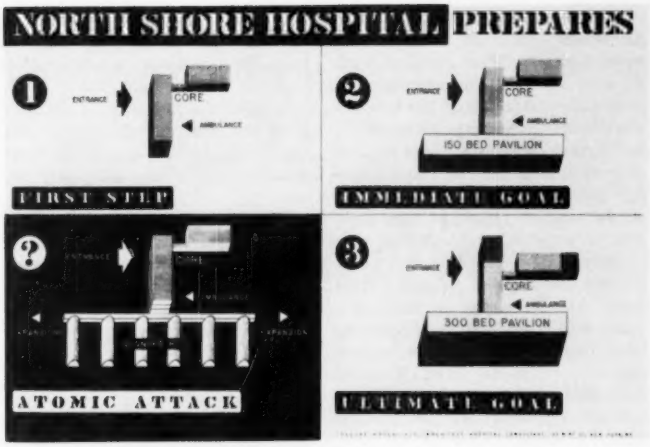
This means that any hospital within three to four miles of ground zero might be rendered useless. And it is precisely in this area that hospitals would be needed desperately.

What to do?

Consistent with good sense, reliance for dealing with civilian casualties could not be placed on hospitals in target areas, but on hospitals out in the suburbs away from target cities and war industry plants. Dr. Kogel recommends organization in depth from the potential target areas ". . . in cooperation with communities perhaps as distant as 75 to 100 miles."[3] But this is precisely where we are most deficient in hospitals—in the suburbs and in rural areas.

This suggests that in the present circumstances preference should be given to hospital projects being planned for communities situated from 10 to 100 miles from key cities and industrial areas. Since hospital construction funds under Public Law 725 (the Hill-Burton Act) have been cut back from $150,000,000 to $75,000,000 per year, it is ever more urgent that state and federal authorities administering the law should favor projects in locations herein described. It would also be reasonable for Congress and the administration to reconsider the cut in funds and substitute a figure that would be commensurate with the need. Hospitals so situated could be built without extra precautions and would be cheaper and make better sense than underground hospital structures or aboveground structures fantastically reinforced and otherwise safeguarded.

The North Shore community of Nassau County, New York, has done some thinking on the foregoing premises and, rather than postpone its hospital project until happier days, decided to proceed now and with dispatch. This hospital site lies in



How the North Shore community proposes to construct its hospital.

[2] Kogel, Marcus D.: When the A-Bomb Falls, Hosp. Management 70:25 (August) 1950.

[3] Kogel, Marcus D.: Problems of Preparing for Atomic Attack, Mod. Hosp. 75:90 (August) 1950.

Manhasset, L.I., about 16 miles from downtown Manhattan as the atomic waves would fly. When the atom bomb question was raised recently, the hospital fund was at about the half-way mark needed to build the proposed 150 bed project. Obviously, it was not possible to build a 150 bed hospital with half the necessary funds, and even if all the requisite funds had been available, it would take considerable time to erect such a hospital.

Upon investigation, I found that the board had the choice of building a much smaller hospital, or of spending all of its present funds on the hospital core. If it did the latter, it would have all the necessary peace-time services for 150 beds, but not a single one of those beds.

This would have been enough to discourage any board, but this board decided to go ahead with the core containing the ancillary, administrative, diagnostic and therapeutic facilities. This scheme had two principal virtues:

1. It would require less time to build the core alone than it would to build the entire hospital, and

2. With the core ready, it should be possible to take care of casualties evacuated from Manhattan or other target areas in tents or other temporary shelters.

True, the core is being designed for only 150 peace-time beds, but in an emergency the same core could serve under strain many more hundreds. The illlustration on page 59 shows this reasoning graphically.

1. Shows the core alone.

2. Shows the whole 150 bed hospital as the community would like to have it as soon as the remainder of the funds is raised.

However, should disaster come, the core could serve hundreds of casualty beds in improvised quarters. Some people speak of impressing schools, churches, armories and so on as emergency medical stations. In the first place such stations are limited to providing shelter and warmth. They would serve adequately to house those who were bombed out, but not those who were seriously injured. As hospitals they would be better than nothing, but they would not have at hand those hospital facilities which would be found in the core of a modern hospital. Furthermore, such scattered improvisations would dissipate the medical and nursing personnel (which also would be depleted by the blast itself) among the many emergency stations.

3. Represents the ultimate need of the community—a 300 bed hospital. The 150 bed hospital is being planned in such a manner as to be expansible to 300 without requiring major surgery on the first increment.

Let us do all we can to contribute toward calmness among nations, but let us be prepared should the storm come.

Fog Room Gives Relief to Respiratory Patients

ACUTE laryngotracheal bronchitis, croup and pneumonia are relatively common diseases and all too often fatal. Dr. George W. Cushman of the Jordan Hospital says, "Authorities in the treatment of this highly fatal disease recognize the supersaturated moisture of the humidified room kept at a temperature of 68°F. or 70°F. to be the most important factor in preventing the extensive crust formation in the tracheo-bronchial tree which has caused such a high mortality. Antibiotics, such as penicillin, are a help but without the humidified room they do not lower the high death rate."

What is this humidified room to which Dr. Cushman makes reference? Last year the Jordan Hospital at Plymouth, Mass., wanted a high humidity room for the care and treatment of patients with bronchitis, pneumonia and similar diseases.

A room about 13 by 9 by 11 feet was waterproofed by facing the walls and ceiling with hard plaster, cement and vaporproof paint. The floor was made with multi-thicknesses of roofing paper and asphalt topped with waterproof cement, with floor drain to dispose of the condensate. A vapor seal was put on the door. To ensure adequate ventilation, the room had both a transom and a window. A bed and crib were covered with rubber sheets when the fog was "on" and the room was ready for the patient. Two humidifiers, each about the size of a table-model television set, were mounted in opposite corners of the room, about 7 feet high. The units need a water supply, drain and regular 110 volt outlet. Red lights at the switches show when either or both are in operation. One unit will bring the humidity up to saturation in about 30 minutes. The other is a spare or for extra fast saturation in emergency.

After spending 36 hours in an atmosphere of 100 per cent humidity and 70° F. temperature, a patient wrote:

"As the first patient to receive the benefit of the new humidified room and to experience the amazing relief it gives, I feel I simply must express my gratitude for this humanitarian project. . . . It will be a special comfort to parents to know that this new aid in saving lives of children is within quick accessibility. The speed with which painful breathing is relieved is almost unbelievable. . . ."

Last summer, another such room was prepared at Burbank Hospital in Fitchburg, Mass. The first patient there probably owes his life to the "fog" room. It was ready just in time to receive a year-and-a-half old boy who was gasping for breath and suffering from laryngotracheal bronchitis complicated by pneumonia. Before he entered the room, hope for saving his life had just about vanished. After 24 hours in the fog room the youngster had recovered so that playing with balloons and looking anxiously for his lunch seemed his chief interest.

These two hospitals are among a few others to be so equipped with this new type of "fog" generation. It is the modern version of the old-fashioned steam treatment for croup and bronchitis. Instead of enclosing the head of the patient in a crude temporary tent over a steaming dish, he is put to bed in the fog room. This treatment is a great deal more comfortable for the patient, as he is lying down and temperatures are kept at a constant 68° or 70°F. Not only are the temperatures more comfortable, but the treatment is considered more effective than those suffocating ones resulting from steam humidification.

Enlightened personnel policies help to reduce

The High Cost of Nursing Turnover

NANCY CROWLEY FOWLER
Personnel Director
The Queen's Hospital
Honolulu, T.H.

EXCESSIVE turnover is expensive and inefficient in any industry. It is especially so in the nursing department where standards of patient care and public relations are adversely affected by a rapidly changing staff. A patient is likely to lose confidence in a hospital if too many of the nurses obviously do not know the hospital routine, and the burden on the experienced nurse is heavier when she has to spend a large portion of her time breaking in a constant stream of new nurses.

Turnover is computed on the basis of the number of persons leaving during a certain period divided by the average number of employes in the department. Most industries consider any figure higher than 20 per cent a year as excessive; many hospitals have a nursing turnover well over 100 per cent a year.

LIKELY TO BE HIGH

Change in personnel is likely to be fairly high in nursing even under good circumstances because professional nurses can find openings in almost any part of the country. Also, a large percentage are young single girls who are likely to marry. Yet, the real reason behind most high nursing turnover is a deficiency in the personnel practices of the hospitals. Before high turnover is charged to an epidemic of matrimony, postwar restlessness, or the instability of the younger generation, a really critical check should be made of actual nursing personnel policies and practices within the hospital.

First of all, are personnel practices for nurses at least as good as those for nonprofessional personnel? Do actual *practices* differ from the written *policies?* Are nurses on a longer work week than other employes? Do they have to work a split shift regularly? Are their days off scheduled far enough in advance so that they can plan a normal social life? Are schedules adhered to, or are days off and half days changed repeatedly at the last minute? Almost no professional nurse objects to working extra time or shifting days off in a real emergency, but few workers want to stay in a hospital where a constant state of emergency is caused by lack of careful, realistic planning.

Routine work for nurses should be scheduled as carefully and checked as often as that for laundry and kitchen help. Are nurses expected to perform superhuman amounts of work in some positions just because no one has checked the job assignment since the positions were originally set up? Changes in technics, in administrative policies, or in student assignments can cause changes in the work load for graduates, and their jobs should be reanalyzed periodically.

How about salaries? State nurses' associations or the prevailing rate in the community may set starting salaries, but what about raises? Do nurses get periodic increases based on merit and length of service? Or do those who complain the loudest get the highest salaries? Do good nurses get raises only if they threaten to quit? Or do they just quit?

One important factor which will help reduce turnover is careful selection of nursing applicants, even during periods when help is scarce. A definite effort has been made at the Queen's Hospital in Honolulu to screen candidates with an eye to their permanency and ability to adjust to the hospital, as well as their immediate availability. Work references are sent by the personnel department on all nursing applicants. Nurses whose references indicate personality difficulties or who have poor marks on cooperation with supervisors or fellow employes are not considered for employment. An effort is made to obtain those nurses whose references indicate above-average ability and personality.

Another factor which may be contributing to high turnover, unless the entire nursing staff is supplied by one's own graduates, is the problem of orienting new nurses to hospital procedures.

TAKE TIME TO ORIENT THEM

Supervisors may feel that they have no time to orient graduate nurses. Actually, two or three hours spent in planning will take the place of many more hours on the floor showing someone how to do things and where to find equipment. For instance, the technic of giving a bath or a bedpan may be the same in most hospitals, but how about the mechanics of ordering clean sheets or taking specimens to the laboratory? Where does one order special linen supplies, what forms are used, where are they kept? What orders need authorization, and who authorizes them? Where is the pharmacy, how late is it open, who has the keys when it is locked?. All these questions, and the many others that a nurse will need to know, will have as many different answers as there are hospitals in the United States. A new nurse will learn these things in time—if she stays long enough—but a planned orientation program will speed up the learning process and help prevent that "lost" feeling which so easily develops into a feeling of resentment and a desire to leave just as soon as possible.

If the nursing turnover in your department is higher than 60 per cent a year, a careful investigation should be made into the reasons. One of the best methods of investigation is to have a terminal interview with each person leaving the hospital's employ to find out the *real* reason. To ensure frankness, the interview should be done by someone other than the department head. Nurses, especially, have pride in

their profession and often hesitate to tell a supervisor about unsatisfactory administrative policies or practices for fear of being considered "gripers."

A neutral person, trained in the technic of nondirective interviewing, can usually get the fundamental reasons for leaving even from an employe who is reluctant to talk. The personnel director who is trained in interviewing and usually has had some previous contact with the worker is the best person to do the interviewing. In hospitals without a personnel department, the administrator or assistant administrator might well do the interviewing. Even employes who have been asked to leave should be interviewed to make sure they understand the reason for separation. This is a step toward good public relations, for it helps prevent the circulation of misinformation throughout the community.

Information obtained from the interviews should be interpreted to the supervisors, not as criticism or "snooping" by the personnel department, but as the results of a carefully planned survey designed to find out what makes nurses leave a particular hospital. No supervisor should fear terminal interviews; both department heads and supervisors alike are interested in the

success of hospital policies, and they should welcome the chance to check their employes' reactions to these policies. They should have confidence enough in the interviewer to realize that criticisms made from personal bias or spite will be carefully sifted from actual facts. Isolated complaints against supervisors are evaluated as such. What the interviewer is looking for is repeated comment on current practices. When one person after another says the same thing about a hospital practice, then you have a significant comment.

Terminal interviews conducted by the personnel department at Queen's Hospital during 1949 indicated three major requests by the nurses. They were:

1. Provision for meeting nurses arriving at the airport or dock and taking them to the nurses' residence.
2. Better orientation of new nurses to Queen's Hospital procedures.
3. Pay increases after a certain period of satisfactory service.

These three requests have been taken care of by now. Representatives of the personnel department meet each new nurse at the airport or dock regardless of the time of arrival, unless the prospective employe indicates that she will be met by friends. The housemother at the nurses' residence is notified in advance of the arrival time so that she is on hand to welcome the new nurse.

A committee of nurses, appointed by the director of nursing, has drawn up an orientation program for new nurses, covering nursing department policies, personnel policies, reciprocity, daily hospital procedure, ward procedure, "paper work" procedure, and a discussion of the various social and religious customs of the Island races.

In September, with the cooperation of the administrator, a raise of $10 a month was scheduled for each nurse completing twelve months' satisfactory service.

MORALE HAS IMPROVED

Comments from the nurses who are still here, as well as the comments in terminal interviews made after these policies went into effect, indicate that their effect on nurses' morale and feeling of cooperation toward the hospital has been marked. We do not claim by any means that the changes just described are solely responsible for making nurses stay longer at Queen's Hospital. There may be a general trend toward the stabilization of employment throughout the country. Another factor is the increased number of our own graduates going on staff following the enlargement of our school of nursing.

However, it is a matter of record that turnover for graduate nurses at Queen's has decreased from 104 per cent in 1948 to 75 per cent in 1949. The reduction was more marked in the latter half of 1949 when the new policies had a chance to show their effect. For instance, 14 nurses left our employ in December 1948, whereas only six nurses left in December 1949. Nine nurses left in November 1948, whereas only three nurses left in November 1949.

The effect of the more stable work force has made the work of the nursing department much easier during these past few months and we believe that the quality of patient care has improved.

Emotion in Gynecological Disorders

A RECENT law suit charging a hospital with failure adequately to protect a temporarily psychotic maternity patient dramatically emphasizes the significance, for hospital directors, of an article by Arthur J. Mandy, M.D., entitled "Emotion in Obstetric and Gynecologic Disorders" published in the *American Journal of Obstetrics and Gynecology*, September 1950.

The incidence of psychosomatic disorders in the obstetrical and gynecological population, the authors write, has been variously estimated in the neighborhood of 30 to 70 per cent. However, owing to the delicate balance and complex integration of the psychologic and physiologic processes of the female reproductive system, one can reasonably assume that almost every woman will at some time develop a psychosomatic pelvic disturbance. Therefore, we believe it to be the responsibility of every physician engaged in this specialty to become familiar with the problem. No other approach can hope effectively to reduce both the great number of pelvic operations unnecessarily performed and the large quantity of hormones irrationally employed.

Unfortunately, more is involved than merely a medical problem. Deeply significant are the broad sociological implications, for underlying countless divorces and broken homes are the many unrecognized, neglected or mishandled sexual disorders. Few mothers with a serious psychosexual disturbance are capable of providing the proper environment for either bearing or rearing emotionally healthy children.

Not every physician, the authors conclude, is obliged to undertake prolonged psychotherapy in the management of these disorders, but it is incumbent upon him to become sufficiently acquainted with the problem to be able to recognize the psychogenic aspects of the illness. Already most alert practitioners recognize that a large proportion of women seeking aid for "female trouble" are instead "troubled females."—MALCOLM SMITH, *Richmond Memorial Hospital, Richmond, Va.*

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

HOSPITAL—HEALTH CENTER

serves Alabama community

Project Cost: $980,000

Cost per bed: $14,000

(including group I and II equipment)

THE Lee County Hospital at Opelika, Ala., was designed by Charles H. McCauley, architect, of Birmingham, to serve an industrial and rural population in the community and its environments. The hospital, as initially planned, has 70 beds, but adjunct facilities are designed with a view to ultimate expansion to 100 beds.

The area includes a number of manufacturing plants, one of the state's colleges, and several small agricultural communities.

In addition to the hospital facilities that were to be provided, the design problem included the integration of hospital and public health facilities. The offices of the Lee County Health Department as well as its laboratory and "health center" facilities are located in the hospital building.

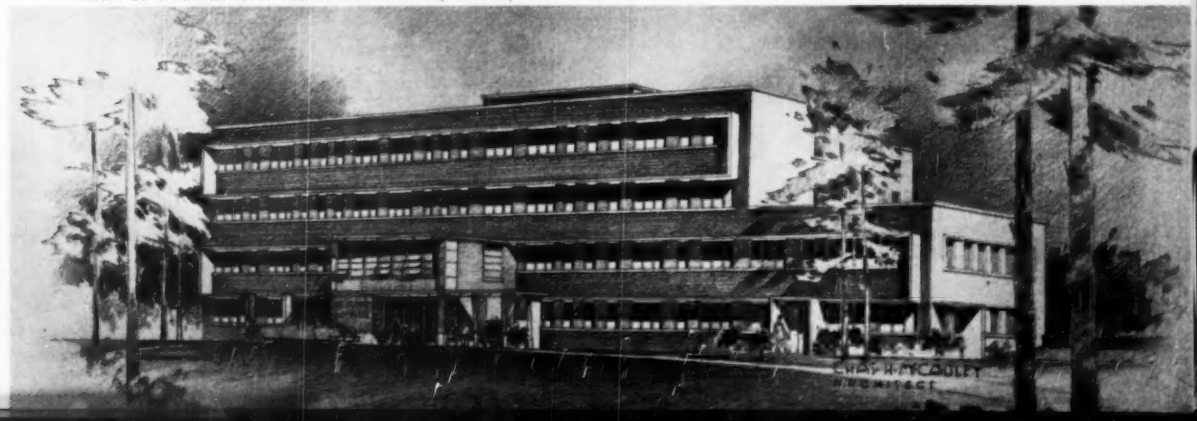
An additional complication from a design standpoint was that parallel facilities in the health department had to be provided for white and colored patients. Separate facilities for white and colored hospital employes also had to be furnished.

Cost of the project was $751,938, including general construction and elevator installation. With the addition of sterilizing, x-ray, surgical and kitchen equipment, architectural and engineering fees, the total cost is $980,000—approximately $14,000 a bed on the initial stated capacity.

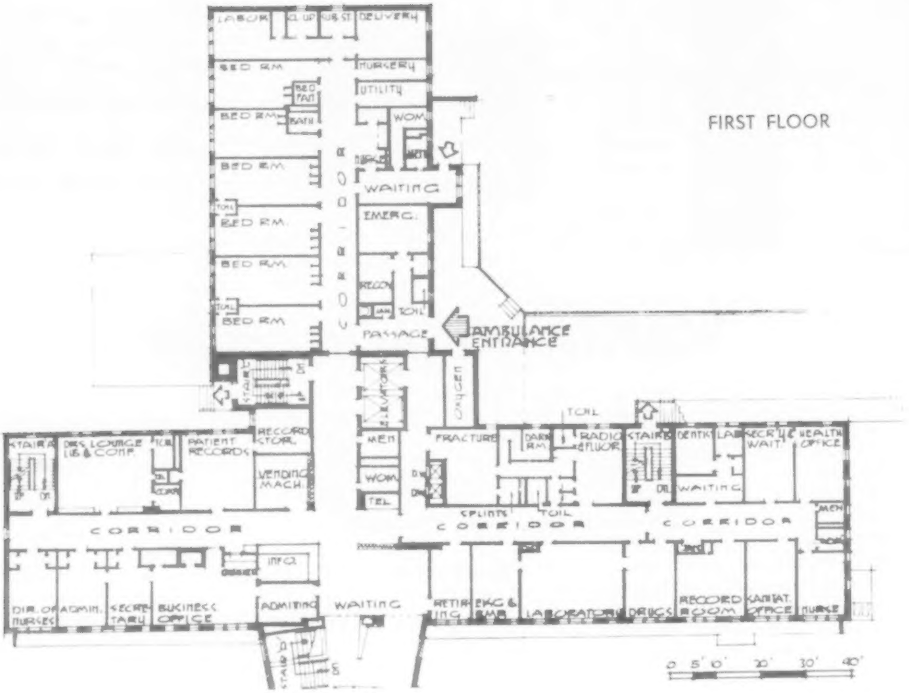
The health department is located on the ground floor and first floor of the main hospital building. Separate entrances are provided for health department personnel, patients and visitors. On the ground floor where both hospital and health department entrances are located, there is no direct access from the health department into the hospital building. On the first floor, however, where diagnostic and outpatient facilities serving both hospital and health department are located, there is a connecting door on the main corridor between the health department and the hospital.

Recognizing the difficulty imposed by the necessity for providing separate locker and bathroom space for both white and colored hospital employes, members of the Award Committee studying the plan felt that the locker room for white female employes should be moved from the area where it is now located (see ground floor plan) to avoid possible objection on the part of white female employes. Members of the committee thought this facility could be located in the space now earmarked for possible use

ARCHITECT'S RENDERING OF LEE COUNTY HOSPITAL, OPELIKA, ALA.



FIRST FLOOR



GROUND FLOOR

as a necropsy room. The committee also noted that the dietitian's office had no outside window and suggested some rearrangement which might permit a pleasanter and more efficient working space for this function.

Details of the structure and equipment follow:

AREA OF BUILDING:

Hospital portion	48,000 square feet
Health Center	3,250 square feet
Total	51,250 square feet

CONSTRUCTION: Concrete frame. Floor construction, bar joist, concrete slab; asphalt tile; terrazzo; ceramic tile. Equipped with two elevators, two dumbwaiters. Air conditioning of surgery suites; delivery suites, and nurseries, with proper control of humidity. Acoustical ceilings in corridors, utility rooms, pantry, waiting rooms, labor rooms, nurseries, dietary department and public spaces.

EXTERIOR: Red brick with limestone trim. Double hung metal windows, with double insulating glass in air conditioned areas.

MISCELLANEOUS: Toilet with bedpan washer connected to each patient room for convenience of nurses and patient. Nurses' travel from nurses' station to patient minimized.

-THIRD FLOOR-

-SECOND FLOOR-

COST:

General construction		$708,954.00
Elevators and Dumbwaiters		42,984.00
		$751,938.00
Equipment:		
Sterilizers	$13,551.00	
X-Ray	15,465.58	
Surgical lights	2,408.00	
Kitchen equipment	11,646.97	$ 43,071.55
Contingencies—4 per cent		103,000.00
Architect and Engineer: Charles H. McCauley, Birmingham, Ala.		49,600.00
Site survey		400.00
Total Cost of Hospital		$980,009.55

Punch Card Accounting

lightens the load of paper work

FRANK R. BRADLEY, M.D., and WILLIAM ANDERSON
Respectively, Director and Comptroller, Barnes Hospital, St. Louis

PAYROLL II

THE detailed steps in connection with the pay roll application of the punch card accounting system are presented in the following paragraphs.

After the department head has notified the personnel department that the applicant has been instructed to report for work, the personnel officer fills out an engagement notice from the person's application sheet and assigns an employe number. On this engagement notice, the personnel officer will record whether or not the employe is receiving room and laundry and, if so, it will be necessary to key-punch a room and laundry deduction card. The engagement notice, group life insurance application, and group hospitalization insurance application cards are then sent to the paymaster. The paymaster checks the coding and information on the cards for accuracy and completeness.

SHOWS CHANGE OF STATUS

A personnel change record card is forwarded to the personnel officer by the department head to indicate any change in work status of any employe in his department. The personnel officer then codes the necessary information on the change card and presents it to the administrator for either approval or disapproval. After the change card has cleared the administrator's office, the personnel officer signs the change record and forwards it to the paymaster for checking.

When the personnel department receives from a department head a personnel change record card, stating an employe has received an increase or decrease in salary, the personnel officer codes the reason for the adjustment in salary and checks the computation. If the adjustment is not according to precedent, the personnel officer sees that the administrator approves the change in salary, then places his signature on the card and forwards it to the paymaster for checking.

If an employe requests his pay check before leaving on vacation, the department head fills in the following data on a personnel change record card: name, employe number, position, department, hospital, number of days to be paid, rate, base and reason. If an employe requests an advance on the next pay period salary, the department head fills in the foregoing information on the same type of card. In both instances, the department head must sign the card and forward it to the personnel officer who will request the paymaster to write a check.

The paymaster checks all cards for accuracy and completeness. On termination and vacation pay cards, the gross earnings, withholding and city taxes are computed. Deductions are obtained from the deduction card file, and the net earnings are computed by subtracting taxes and deductions from the gross earnings. All computations are recorded on the back of the personnel change record card. On pay advance cards, no computations are made; therefore, only the amount of the advance is recorded on the back.

The paymaster then types a check showing the following: date, employe number, gross earnings, group life insurance, group hospitalization insurance, miscellaneous deductions, and net earnings. A carbon of each check is made and attached to the personnel change record card. From the carbons, the paymaster fills out the prepaid check listing which is sent to the tabulating department at the end of each pay roll period. The check is then ready to be forwarded to the personnel department.

At the end of the pay period, the

PERSONNEL ENGAGEMENT NOTICE

NAME JOHN DOE — ADDRESS 16 HIGH, ST. LOUIS, MO.

EMPL NO. 1345 — NEW X — REHIRE — BASE R — TAX CODE 1

S.S. NO. 480-08-9860 (M F W C) — EDUCATION R — PERIOD SALARY OR RATE 100.00

SEX X 1 2 — RACE X 1 2 — DATE EMPL 10-01-49

SING. 1 DIV. 4 — MAR. X 2 SEP. 5 — WID. 3 — HOSP. 1 — DEPT. 4151-1 — COL. 72 73 74

BIRTH DATE 9-16-18 — POSITION 210 — DEPT. HEAD Mary Smith

SHIFT: 1st X 1 2nd 2 3rd 3 SPLIT 4 — NURSING DIV. 21 — PERSONNEL DIRECTOR Martha May

The engagement notice is filled out from the employe's application sheet. The personnel officer indicates whether the employe is to receive room and laundry; if so, a room and laundry deduction card is key-punched.

This is the fifth article in a series by Dr. Bradley and Mr. Anderson on the machine accounting procedure in use at Barnes Hospital, St. Louis. Successive articles on this procedure will appear in forthcoming issues of this magazine.

paymaster forwards to the tabulating department the engagement notices, personnel change record cards, and termination notices of the preceding pay roll, together with all of the department change cards of the preceding pay roll.

From the engagement notices, the key-punch operator will key-punch a pay roll master card, which contains the name, employe number, social security number, hospital, account and suffix number, entry, nursing division (if employed in the nursing department), shifts, marital status, tax code, base and period salary or rate. The amount to be key-punched for employes paid on a monthly basis is their monthly salary; for those paid semimonthly the amount is one-half of their monthly salary; for those on an hourly basis it is the amount per hour; for those on a daily basis it is the amount per day, and for employes in the beauty shop and barber shop, it is based on a percentage of their sales. On the pay roll master cards only, the number "1" is key-punched in the marital status column if the employe is single, widowed, divorced or separated, and a "2" if married, because on the W-2 form a "1" is printed if the person has a single status and a "2" if he is married.

USED TO PREPARE W-2 FORMS

Address cards are key-punched with street number, name of street, and employe number on one card, and the city and state and employe number on a second card. These cards are used to prepare W-2 forms.

Personnel statistics cards are key-punched with name, employe number, social security number, sex, race, marital status as indicated on the engagement notice, date of birth, shift, whether he is a new or rehired employe, education, date employed, hospital, department number, position, base and period salary or rate. These cards are forwarded to the operator for verification; cards that have been key-punched on employes who have had a change in salary or change in department are held.

Only on salary change cards are the personnel statistics cards pulled. The pay roll master card is not pulled on department changes because the employe may have worked part of the pay period in one department and the remainder in another department; therefore, the employe's name will appear on both time sheets and he will receive a check from both department heads. This permits the employe's salary to be charged to the right department, so that one department will not bear part of the other's salary expense. This old pay roll master card is then discarded.

NOTE INCREASE OR DECREASE

On the old personnel statistics card of changes in position, the date of the change and the reason are key-punched. On the salary change card, the date of adjustment in salary, amount of adjustment, and the reason are key-punched. An "X" is key-punched in column 51 if the adjustment is a decrease so that if an abstract of an employe's record is requested, any decrease in salary will have a credit symbol to the right of the amount. A new pay roll master card and a new personnel statistics card are key-punched and verified. Pay roll master cards of changes are placed with those of new employes, and are interpreted by printing employe number, social security number, hospital, account and suffix number, nursing division, base, period salary or rate, and tax code. The personnel statistics cards of changes are placed with those of new employes and are interpreted by printing the employe name, employe number, social security number, base, period salary or rate on the first line, and sex, race, marital status, birth date, shift, education, date employed, hospital, department, position, adjustment in salary, date of adjustment and reason on the second printing line. The new personnel statistics cards are then sorted by employe number and merged into the active file on the employe number. The old personnel statistics cards are merged into the inactive file by employe number.

Pay roll master cards of new employes are reproduced to make the off-staff listing. The pay roll master cards of new employes and of changes are placed in the pay roll master file. Using the department personnel change record card of preceding pay roll, the clerk pulls the pay roll master cards from the pay roll file and discards them. The file is now ready for the time sheet procedure.

DEDUCTION CARDS KEY-PUNCHED

From the engagement notices and personnel change record cards relating to salary changes are key-punched the deduction cards for room and laundry for nurses living in the nurses' residence. In the salary block on the card will appear the semimonthly salary minus allowance for room and laundry. Key-punched on the deduction card are the name of the deduction, hospital, account and suffix number, entry, employe number, name of employe, and figure for allowance of room and laundry in the amount field. The deduction cards are then verified.

The following is interpreted: name of employe, employe number, account number, suffix number, name of deduction, and amount of deduction. These cards are sorted with cards in the room and board file on employe number, hospital and account and suffix number. The room and laundry cards are then listed, and the listing is forwarded to the pay roll clerk who records the amount of room and laundry to be deducted and who will then forward the listing with the time sheets, return engagement notices, personnel change record cards, termination cards, and department change record cards from the preceding pay roll to the paymaster.

PERSONNEL CHANGE RECORD

NAME JOHN DOE		EMPL. NO. 1345	HOSP. 1
DEPT. 4151-1		POSITION 210	
SALARY ADJ.	CHANGE IN POSITION		TERMINATION
DATE AUTHORIZED 10-24-49	DATE AUTHORIZED 10-24-49		DATE
DATE EFFECTIVE 11-1-49	DATE EFFECTIVE 11-1-49		REASON ☐
OLD SALARY	FROM 1-4151-1 HOSP. DEPT.		
100.00	POSITION 210		PREPAY FOR DAYS
ADJ. 2.50 / NEW SALARY 102.50	TO 1-41214-0 HOSP. DEPT.		FROM INCL.
	POSITION 211 SHIFT 2 NURSING DIV.		RATE BASE
REASON ☐ A	REASON ☐ G		
DEPT. HEAD Mary Smith	PERSONNEL DIRECTOR Martha May		COMPTROLLER DIRECTOR Robert Gaines

Any change in work status is recorded on the personnel change record card. Personnel officer codes necessary information on the change card, clears it with the administrator and sends it to the paymaster.

CHRISTMAS comes to the hospital

"SCRUB POWDER ART" TRANSFORMS PRESBYTERIAN

GEORGE W. WHARTON
Administrative Assistant
in Charge of Public Interest
Presbyterian Hospital
New York City

ONE seems to enter a different world in the Presbyterian Hospital in New York at Christmas time. On glass partitions are lovely winter snow scenes. Doors may be transformed into church doorways. On nurses' stations, telephone booth doors, utility room door panes, windows and on all glass partitions available are Santa Clauses, Christmas trees, choir boys, angels, candles, not to mention a few comic figures, and last year the most popular character of all, Rudolph the Red-Nosed Reindeer.

Probably the fact most characteristic and thrilling about "scrub-powder art" or window painting at the Columbia-Presbyterian Medical Center is that it is so spontaneous. Although rivalry is high, competition is not organized. There are no prizes offered. It is a project embracing all the hospital units of the Presbyterian Hospital where professional personnel, patients, visitors, clerks and all alike try their hands at art and simply have a good time doing it.

Window painting is not limited to patient floors. Office windows, the cashier's window, clinic windows, the soda fountain, the cafeteria, all are colorfully decorated, and everyone throughout the hospital enjoys and takes pride in the results of "scrub-powder art."

"Scrub-powder art" has added bright color and new spirit to Christmas for the patients and staff at Presbyterian Hospital in New York for many years. Although this type of art had its beginning in the early days of the "hasn't scratched yet" advertising campaigns, it received real impetus only in the last decade when the use of inflammable materials was forbidden—with paper Santa Clauses, red paper bells, Christmas streamers, tinsel and real pine Christmas trees, which were not fireproofed, banned from hospitals by fire laws. Then, too, during the war traditional Christmas decorations were scarce and costly. The substitution of "scrub-powder art" on the windows and glass partitions of the wards, rooms and offices of the hospital supplies a much gayer form of decoration and brings together doctors, nurses, patients, patients' visitors, technicians and administrative personnel in a common bond of Christmas spirit activity.

Even though a ward patient is not well enough to paint a picture himself, nurses and doctors find that merely watching the paintings being done is wonderful recreational therapy. The patient has the real enjoyment of seeing the nurse, doctor, technician or visitor do the painting. After receiving subject suggestions from ward occupants, the artist outlines his drawing on the door or window of the ward and then mixes his paints—usually white scouring powder, plus water, and poster paints for color. Patients often have words of advice—

Photograph by Frank F. Ericson

This candle-puffing gnome gave pleasure to child patients last Christmas. Medium used: tempera paint and scouring powder.

Photograph by Frank F. Ericson

A third-year art student, husband of a social worker, volunteered to paint this jolly Santa Claus on the door of a ward.

Wide World Photograph

Student, nurse, in off-duty hours, paints colorful Christmas scenes on nursery windows, using poster paints and scrub powder.

such as, "a little more red on the reindeer's nose" or "Nurse, please give that angel bigger wings," or "Santa's not fat enough." The professional staffs feel that the therapeutic value of the project for patients is fine.

More and more, with early ambulation, patients are well enough to be the artists themselves. Last year, on a window in the women's surgical ward, there was a lovely church scene of three golden-haired choir boys in red gowns with white surplices. The artist, a patient, an interior decorator by profession, said it was her first experience in working with paints made from scouring powder. She was scheduled for an operation, but hoped to be well enough after it to do another painting before Christmas. This was typical of the enthusiasm shared by patients, nurses and personnel alike.

"Scrub-powder art" started as just that—pictures done on glass with scouring powder plus water and with mercurochrome or other "local coloring" matter added. However, in the last two years the Columbia-Presbyterian Medical Center Christmas artists have been leaning more and more to the use of poster paints or tempera. These give a clear-toned and more striking color. Often the artists work from Christmas cards—copying their designs and colors. Others, more creative, make original designs.

ARTISTS WORK OVERTIME

Window painting at Presbyterian begins about 10 days before Christmas and usually is complete about five or six days later. Paintings are washed off anytime during the first week of January. The result is sparkling clean windows. Each ward in the hospital is allotted for presents and decorations a small amount of petty cash from the "Christmas Cheer Fund," a fund supported by special contributions. A very little of this goes to the purchase of poster paints and brushes. Then, the nurses, doctors and technicians paint in free moments. Often they come in after hours to finish their work on Christmas art. Last year one night nurse completed her snow scene by flashlight after hours. A messenger who attends art school at night stayed late for several evenings to paint snow men and Santa Clauses on the glass partitions of the children's neurological ward.

Each year hidden talent is discovered. Many times someone who has "never wielded a brush before" has his try, and finds what fun it is. And also there are the professional artists, such as the male nurse in Neurological Institute who has exhibited his paintings throughout the country. He created a skilled Star of Bethlehem scene on the chart room door which attracted considerable comment.

One added "plus" value that has resulted from "scrub-powder art" at Presbyterian Hospital is as an aid to the public relations program. Not only does the "art" favorably affect patients, visitors and employes but, in addition, every year it warrants an illustrated feature story in local papers.

WARD DECORATION CONTEST AT MILWAUKEE COUNTY

brings happiness to patients and employes

MRS. ELIZABETH S. KLETZSCH

Personnel and Public Relations Director
Milwaukee County Institutions, Wauwatosa, Wis.

DURING the last Christmas season, the Milwaukee County Asylum sponsored a contest in ward decoration among its 400 attendants. The usual custom has been to furnish each ward with a Christmas tree and its decorations, and art supplies which are available through the occupational therapy department. Last year, however, competition among the wards showed interesting results not only in making the holiday season happier for the patients but also in training attendants. In the Nov. 28, 1949, weekly bulletin to employes, it was announced that three prizes would be given to the most attractive wards. The bulletin emphasized that originality, resourcefulness, charm and so forth would be among the factors in judging, but that encouragement of patient participation was of first importance.

Response in the beginning was rather mild especially on the men's wards. Additional reminders in the weekly bulletins, however, gradually quickened interest. Extra materials were bought with money previously donated by relatives, friends or com-

An alcove decorated as a chapel with an altar won the first prize.

munity agencies. Cardboard chimneys and manger scenes which had been used on the wards from year to year became central themes around which larger displays were developed.

There were several difficulties in this project for attendants. Milwaukee County Asylum cares for 2260 mental patients, the majority of whom cannot be rehabilitated to return to the community. There are many old people with arterio-sclerotic mental conditions, mental defectives, epileptics and others. The fact that the average age is 67 years is indicative that patient participation was limited. Another drawback was lack of funds. Fifteen dollars in donations was the only addition to the regular Christmas budget, although some of the attendants purchased decorations with their own money. This fact was not as unfortunate as first imagined since it called upon the resourcefulness of all.

The results of this Christmas preparation were surprising and gratifying. Attendants who had never before shown any artistic talent or interest produced colorful and attractive designs which they painted on the windows or cut out of colored paper for the walls. They worked with their patients and were able to encourage some of the least cooperative to share in coloring and cutting figures. Patients helped to decorate trees and arrange pictures on the walls and contributed their own personal Christmas cards to arrange in the shape of a star or Christmas tree. Brown wrapping paper was covered with colored Christmas scenes and water color paints were used to decorate windows. Patients showed great pride in their contributions and even on the most disturbed wards they were careful not to destroy their work. Only in isolated instances did they harm the decorations.

For another story on Christmas activities, and how volunteers can contribute to the Christmas spirit, see article on Page 82.

The men's TB ward, which was given the first prize, used an alcove to decorate as a chapel with an altar. This scene was especially significant to them since these tuberculous patients were unable to attend church services with the other groups. Under the supervision of the attendants, the windows of the alcove were painted by the patients to look like stained-glass church windows. Religious pictures and a draped sheet as a back drop also added to the scene. Special services and communion were held in this chapel on Christmas, and some patients used it throughout the season to pray at the crèche. Of interest was the religious theme which dominated the scenes on all of the wards. This trend apparently was an unconscious one and was recognized only at the time of judging the wards.

The most disturbed women's ward, in spite of the many handicaps incident to the type of patient, won second place. Here, again, patient participation was outstanding. The decorations were colorful and effective yet simple enough for all patients to make.

HARD TO CHOOSE WINNERS

Choosing the prize winners was a difficult task inasmuch as every ward showed that much time and energy had been spent on this project. The decisions were accepted well by all, however, and there was a general feeling of enthusiasm and accomplishment. The wards are using their prize money on projects, such as Valentine parties, chocolate bars, cigars, cigarets, ice cream, and games.

This contest was of value to patients and also to the attendants; both gained holiday happiness through helping others. The patients, having contributed to the decorations, valued them more and actively entered into the spirit of the season. The various activities became for them a way to express themselves. Many patients stated that this 1949 Christmas was the most enjoyable they could remember. Flash bulb pictures were taken of the prize-winning displays and many are keeping them as souvenirs.

For the attendants, this project was more than just another way to bring interest into their patients' daily routine. It was a lesson to them that many patients who are thought too senile or disturbed to participate in ward activities could and would if they were helped along. It was proof to them that their jobs are essential not only in promoting physical comfort of patients but also in encouraging the patient to become a more interested and satisfied human being.

CHILDREN'S PARTY AT SHEBOYGAN

MRS. GERTRUDE OLSEN, R.N.
Superintendent, Sheboygan Memorial Hospital, Sheboygan, Wis.

ON DEC. 27, 1949, we invited all the children who had been patients during the year to come to the hospital for a Christmas party. The children enjoyed the party very much and the mothers were especially pleased.

Many of the children told us they wanted to get sick again so they could come to the party in 1950. The mothers mentioned the fact that they were very glad to bring the children for a party so that when they had to come as patients they would have a good feeling for the hospital and would not be afraid to come.

MORE THAN 150 GUESTS

The idea for the party was suggested by Dr. F. A. Nause, and it was put on by members of the Sheboygan Memorial Hospital Guild and the hospital staff. More than 150 children came from Sheboygan County, Kiel, New Holstein, Manitowoc and other communities.

Santa Claus distributed gifts to the youngsters, and soft drinks and popcorn balls were served to them. Coffee and doughnuts were provided for the mothers. The informal program included the singing of "Silent Night" and a monologue read by Mrs. Sylvester Schultz, a member of the guild.

The party was reported in the *Sheboygan Press*, which sent a photographer to take pictures of the children.

We plan to make this an annual affair, just as we hold an annual "Baby Day" in the summer. On the third Thursday in July we invite all the babies who have been born here during the last three and a half years to come with their mothers to the hospital. They are entertained on the hospital lawn; the mothers are served a lunch and each child is presented with a box of animal crackers and a bottle of pop. We usually have about 500 babies at that party.

The Christmas party is for children from 3½ to 12 years old.

STOP THIEVES *by setting up controls*

to protect patients' and employes' belongings

KENATH HARTMAN
Assistant to the Superintendent
Wesley Memorial Hospital
Chicago

ONE of the responsibilities facing a hospital administrator is the establishment of an effective program for the protection of the patient's personal property. This program involves two major conditions: first, the personal property which the patient turns over to the hospital for safekeeping; second, the personal property the patient retains with him in his room.

In each case the program adopted must give adequate protection to both the patient and the hospital. The first pertinent step would be to put the hospital policy on record. This should clearly indicate that the institution is not responsible for property and valuables which are kept in the patient's room. To ensure that the patient receives this information, a statement to this effect should be placed on the admission data social history form. This is usually noted by the patient's signature on his admission sheet. Some hospitals go even farther by posting signs in a conspicuous place in the admitting area. Patients' information booklets are issued warning the patient against taking valuables to his room.

INSTRUCTIONS TO PATIENTS

The experience of a Chicago hospital showed that losses occurred while valuables were in the safekeeping of the institution. To protect money, jewelry and other valuables, the new patients admitted to this hospital are instructed as follows:

1. The hospital prefers that all cash in excess of $10 be deposited to the credit of the patient's account and that all jewelry and other valuables be sent home by a relative or friend. (Any credit balance remaining on the account at time of dismissal will be refunded at that time.)

2. If this cannot be accomplished, money and valuables shall be checked in a valuables envelope.

A system of internal auditing was necessary to ensure that the hospital gave every patient adequate protection. The comptroller knew the weakest points and so was able to effect a program that has proved itself —no losses of patients' valuables in one year. A brief discussion of this program may aid those who have experienced similar conditions.

Numerically sequenced valuables envelopes are kept in the admitting office. For each envelope there is a receipt for valuables completed in triplicate which includes a brief description of any jewelry, together with its value if given by the patient. Cash, checks and other valuables are listed in reasonable detail in order to serve as a record of the envelope's contents.

In taking an envelope for use, the admitting interviewer checks to see that a receipt for the preceding envelope is on file and accounted for to make certain that no envelopes are missing in the numerical sequence. A receipt is completed for the new envelope with the signatures of the interviewer and the patient signed on the proper lines indicating approval of the description of the envelope's contents. If someone other than the patient is placing the valuables in safekeeping, this individual must sign his name and add "for (name of patient)."

The duplicate copy of the receipt is placed in the valuables envelope. This envelope is then sealed in the presence of the depositor and taken immediately to the cashier's office along with the original and triplicate copy of the receipt. The cashier receiving the envelope signs copies of the receipt and the original is given to the patient. The admitting interviewer must remain at the cashier's window until she has seen that the envelope is registered in a "valuables envelope register" by the cashier and placed in the safe. This is necessary for protection of both individuals. The admitting interviewer places the triplicate copy on file in the admitting office.

NOTES DISPOSITION OF VALUABLES

Under the "remarks" section of the patient's admitting registration form will be noted the disposition of the valuables in one or more of the following ways to indicate their status.

1. "Valuables sent home with relative (friend)."
2. "Cash deposited to credit of account."
3. "Valuables checked in Envelope No. ....." (Note: Do not list contents of envelope on Registration Form.)
4. "Will take valuables to room."
5. "Patient states no valuables."
6. Other explanation as appropriate.

By prearrangement, one employe in the cashier's office has access to the valuables envelopes and is designated as the custodian. If necessary, the custodianship may be transferred, but each transfer must be recorded and audited. The custodian is usually the employe who accepts and signs for envelopes received from the admitting office.

The valuables envelopes have a self-locking metal seal which cannot be opened unless the envelope is torn and the metal lock damaged. Another outstanding feature of this envelope is that each lock is anchored; this means a tell-tale mark is left where tampering is attempted. When a patient claims his valuables, the custodian, in the presence of the patient, slits the envelope, opens it and verifies the

contents against the duplicate receipt which is in the envelope. The custodian then asks the patient to sign for receipt of the valuables on the front of the envelope and to surrender the original receipt. If this signature is the same as that signed at the time of checking valuables, the custodian delivers the valuables to the patient. Both receipts are then stapled to the front of the envelope and placed in the safe. The numbered envelopes are scratched from the register when the contents are returned to the patient.

The custodian going off duty and the one coming on duty check the valuables envelopes against the register to make certain that all envelopes listed in safekeeping with the hospital are actually in the box. Both individuals sign the audit record to indicate that an audit has been accomplished. This procedure also indicates the time of transfer of custodianship. The continuous audit report form is filed in the same binder with the valuables envelope register.

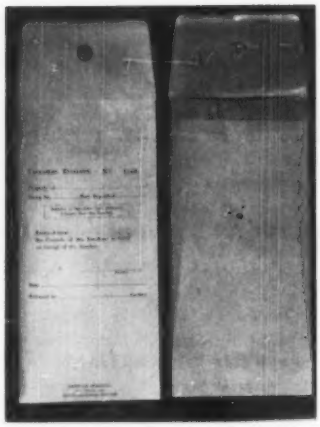
MAKES DAILY AUDIT

In addition to the continuous audit of valuables envelopes performed by the custodian at each change of custodianship, another hospital employe, the internal auditor, performs a daily audit. This audit consists of the following:

1. Examination of each envelope redeemed since last audit to make certain that receipts of each envelope are attached and that depositor's signature on release agrees with signature made at time of deposit. If all is in order, the auditor initials the valuables envelope register in the "Release Audited by" column.

2. Proof of total envelopes in box by adding to the total at previous day's audit the number of envelopes placed in safekeeping since that time and subtracting the number redeemed (which will be verified by a physical count of the redeemed envelopes). The resultant total will be checked by a physical count of the envelopes in the box. The record of this daily proof is maintained by the internal auditor separately from the valuables envelope register.

In spite of all the warnings that valuable property, keepsakes and heirlooms should not be brought to the hospital, the patients do take their personal effects with them. They are not in the frame of mind to give any thoughts to petty thievery. When the patient is admitted to a hospital, he is primarily concerned about his immediate comfort and ultimate prognosis of his illness. After all practical precautions have been taken and the patient's keepsake disappears from his room, he feels that some means should be taken by the hospital to fulfill its obligation of guardianship.



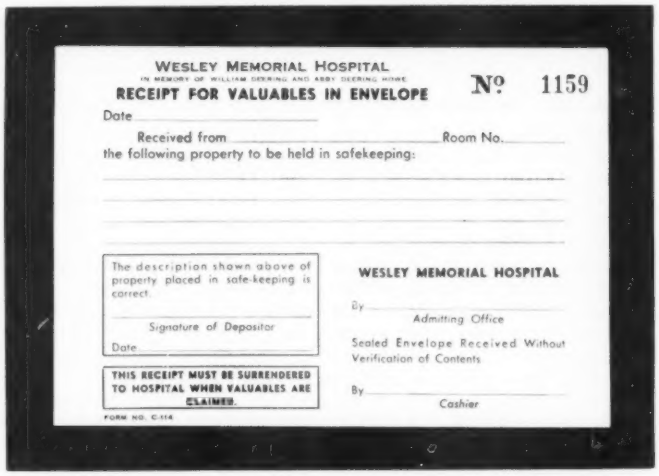
The valuables envelope is made tamper-proof by the use of a metal seal which cannot be opened unless the envelope is torn and lock is damaged.

Pilfering in hospitals can be a continuous problem to the administrator who sits back and admonishes the patient for having taken his valuables to the room against the advice and precautions taken by the hospital. Admonishment of the patient is not the solution.

The problem of pilfering from patients and employes is one that is found in some degree in many hospitals. But the hospital must assume the responsibility, for the patient has a right to be protected from the scavengers who prey upon the sick and helpless. In some instances they take various articles of clothing as well as money and jewelry. The problem usually lies within the hospital family. Through the comprehensive program of personnel administration in our hospitals today, it is hoped that by careful screening the hospital family can be looked upon without suspicion. As in every large family, some fall out of line and must be policed. How can the hospital effectively police its family?

The follow-through on cases of pilfering at one hospital has been invaluable. The time and effort given to a planned system of checking each reported theft reap rewards when the guilty individual is found. For petty thievery, it was not necessary to have the mechanical paraphernalia of the police department to apprehend the guilty one.

If any individual is under suspicion, the present laws protect that individual's rights both to personal liberty in the sense of freedom from restraint and to his freedom from any intentional application of force to any part



WESLEY MEMORIAL HOSPITAL
IN MEMORY OF WILLIAM DEERING AND ABBY DEERING HOWE

RECEIPT FOR VALUABLES IN ENVELOPE No. 1159

Date _____

Received from _____ Room No. _____
the following property to be held in safekeeping:

_____

_____

_____

The description shown above of property placed in safe-keeping is correct.

_____
Signature of Depositor

Date _____

THIS RECEIPT MUST BE SURRENDERED TO HOSPITAL WHEN VALUABLES ARE CLAIMED.

FORM NO. C-114

WESLEY MEMORIAL HOSPITAL

By _____
Admitting Office

Sealed Envelope Received Without Verification of Contents

By _____
Cashier

The receipt for valuables has space for a description of property placed in the envelope. It must be signed by the depositor and the interviewer.

of his body without consent. To detain an individual for search without his consent, expressed or implied, lays those concerned open to actions both for false imprisonment and for assault and battery. The program was thus developed to apprehend those individuals through a simple system of record keeping.

When a loss is reported by a patient or employe, immediately an "Unusual Occurrence Report" is completed by a member of the nursing department to whom the report is first made. This report has the following information: name of individual who suffered the loss, date, time, room and floor number, name of the individuals who were present on the floor at the time of loss, and, last, a clear description of what actually was lost.

The report is completed in duplicate and sent to the nursing office immediately; one copy is forwarded as soon as possible to the superintendent's office from the nursing office. It is at this time the detective work begins. The cooperation of all departments is needed.

ALL NAMES RECORDED

The housekeeping department is responsible for the cleaning of a room when a patient is discharged. At no time is a housekeeping employe allowed on a patients' floor unless his name has been recorded in a register of that department. The employes are known as check-out maids who move from floor to floor cleaning and returning a used room to order.

The nursing department maintains a daily personnel assignment sheet. Orderlies, student nurses, graduate nurses, nurse's aides, and other auxiliary help of the nursing service are listed.

The store receiving department maintains a register of outside deliveries made to a patients' floor, such as flowers and food. These deliveries are made by the service department employes as outsiders are not allowed to make deliveries to patients' floors.

The laboratory maintains records of all laboratory tests made on the floors. Reference can always be made to these records to determine whether a technician was on the floor at the time a loss occurred.

Of course, there are many other individuals coming to the patients' floors. Through interrogation of regularly assigned personnel at a nursing station, there may be added many more to the list of suspects concerned in a reported loss.

An index is so arranged that each individual in the area where a loss occurred may be identified accordingly. Briefly this index is divided into eight sections. For each letter of the alphabet there is an individual sheet. The names of all the employes who were in the area of a reported loss are listed alphabetically throughout the index. Their positions in the hospital — registered nurse, student nurse, check-out maid, orderly—are recorded. The room number in which the loss was reported is also shown. Each original report of loss is numbered in the superintendent's office so that cross-reference is easier. On the index sheet is listed the article that was reported missing together with the time and date. The last column indicates the action taken, such as "interviewed," "suspected by personnel," and so on.

After all these names have been posted to the index, a summary of losses by floors in the hospital is made. The floor summary indicates the date and room number in which a loss was reported. On reviewing such a record over a period of time (which might be 20 or 30 reported cases) another lead is made available. Should there be a predominance of losses and thefts from one section then a review of the permanent personnel of that section should be made.

HOW THE PROGRAM WORKS

An interesting experience shows how well this program operates.

On Feb. 13, 1950, a seriously ill patient was transferred from a two-bed room to a private room. After the transfer was made, the family could not locate the patient's purse which contained valuable personal papers. A listing was made of all employes who were on the floor at the time of the transfer. The names were transcribed to the index. In this report there were eight individuals in the area at time of the loss. Let us assume their names were "A," "D," "F," "K," "N," "P," "S," "W." These names were recorded alphabetically in the index.

On March 13 a pair of slippers was lost. Through this method of investigation, we discovered the employes involved were "B," "R," "W," "Z." Their names were recorded.

On April 17 a housecoat was missing from a patient's room. The personnel involved included "C," "G," "H," "K," and "W." Their names were recorded.

Again on April 21 another housecoat was reported missing. Those individuals involved were "C," "E," "W" and "Y." Again the names were recorded to the alphabetical listing.

From these four losses a survey was made of the names posted to the index. Immediately it was evident that one or two individuals were in the area of a reported loss more than once, but on a more careful check, "W" was found in the area on all four occasions. The record obviously indicated a definite suspect. The hospital could not afford to accuse her on such circumstantial evidence, but could plan to make it easier for "W" to continue her possible pilfering under "supervision."

MARKED CURRENCY USED

Ten dollars in marked currency was placed in a room that was to be made ready for the new patient. "W" was asked to clean the room as soon as possible for an emergency. She jubilantly turned in $9 of the $10, claiming that $9 was the total amount found. The plan of apprehension had worked. After being questioned at length "W" admitted that there was another dollar. Definite proof of this was established by the recorded serial number. Several days after "W" was discharged from employment an admission of guilt was made.

As time goes on, the number of losses that might accumulate are gradually decreased by the weeding out of undesirable hospital personnel. It might be admitted that not all individuals so suspected will admit any guilt. The knowledge that they are under suspicion limits their activity because of fear of disclosure. They may solve the problem for the administrator by resigning. For those who continue their employment, the hospital has a complete record on their past activities.

Such a program for the protection of the patients may appear time-consuming and complicated. The conscientious efforts of the hospital family to solve the problems of losses and thefts are more than repaid by the systematic degree of control achieved. The resultant minimum of thefts, losses and disappearances of patients' belongings has made the hospital its own detective. The good will created by the hospital's interest will pay generous dividends.

CREDITS and COLLECTIONS

A MODERN HOSPITAL ROUND TABLE

HEREWITH The MODERN HOSPITAL introduces a new series of features—round table discussions of operating and administrative problems that are common to all hospitals. Periodically, we will invite a group of administrators to sit down in our editorial offices and talk about their problems. A recording of the conversation will be made, and the transcripts will be published here—after editing to eliminate repetition and irrelevancies. Hospitals of all sizes and types will be represented in these discussion groups, but the problems selected for discussion will be those that seem to appear in all kinds and sizes of hospital. Readers are invited to write to the editors suggesting topics for discussion at the administrators' round table.

The first subject chosen was collection methods and practices. Taking part in the discussion, a transcript of which appears here, were Mrs. Edna Nelson, administrator of Women's and Children's Hospital, Chicago (125 beds); Dr. Stephen Manheimer, director of Chicago's Mount Sinai Hospital (285 beds), and Richard D. Vanderwarker, administrator of Passavant Memorial Hospital (225 beds). Everett W. Jones, technical adviser to the editorial staff of The MODERN HOSPITAL, acted as moderator for the discussion.—THE EDITORS.

MR. JONES: The question we are going to discuss today is that of the growing volume of accounts receivable and the credit and collection problem this presents to hospital administrators and their financial officers. What experiences have you administrators had on your accounts receivable? Do you find them going up or down—or what is the picture?

MR. VANDERWARKER: We haven't experienced an upward trend. I don't think there is any greater difficulty with collections than there was a year ago.

MRS. NELSON: During the summer and spring we noticed accounts receivable increasing. However, there is a little letup now, and there seems to be a little more money available.

MR. JONES: Apparently the temporary slump in employment has stopped, and with an increase in employment people have more money to pay hospital bills.

DR. MANHEIMER: Our collections are stable. There has been a slight drop-off. Collections are a little more difficult, not because people are not willing to pay, but our volume has increased and we require a special credit manager and collecting agent to collect bills. Not infrequently patients go home without having paid their bills, and it seems to be up to the hospital business office to see that the money comes in.

MR. JONES: In other words, collections are sometimes neglected and not enough effort is put in on them?

DR. MANHEIMER: Not necessarily. Early last year, one of our board members was approached by an outside collection agency, asking about our accounts receivable and offering to try the collections for a fee. The trustee brought this up at one of our meetings and we discussed it very thoroughly. The consensus was that we probably can do a better job ourselves, without having to pay a fee and without possibly causing bad public relations as sometimes results when outside collecting agencies approach your patients.

MR. JONES: What do you figure your percentage loss in bad debts really is?

DR. MANHEIMER: We consider 2 per cent as our write-off. We write the account off after three months, but at a later date we may attempt to collect, and then find the loss is less than 2 per cent. In other words, we collect some of the write-offs.

MRS. NELSON: Our loss at Women's and Children's is only about 1 per cent.

MR. VANDERWARKER: We have a particularly advantageous position, with less than half of 1 per cent.

DR. MANHEIMER: You mean one-half of 1 per cent is your original write-off, or is this after an attempt is made to collect?

MR. VANDERWARKER: That is after all.

DR. MANHEIMER: How long do you yourselves try to collect?

MR. VANDERWARKER: Ninety days. Beyond that point we may turn the account over to a collection agency.

DR. MANHEIMER: Oh, you use a collection agency?

MR. VANDERWARKER: We do in some cases, where we think we have done all we possibly can.

MRS. NELSON: We do, too.

DR. MANHEIMER: What routine do you employ to collect these bills during the first 90 days after the patient leaves?

MR. VANDERWARKER: We send a series of credit letters, then we begin to telephone—in the usual effort on the part of a credit manager.

MRS. NELSON: You have a special person to do that—a full time credit manager?

MR. VANDERWARKER: Yes.

DR. MANHEIMER: We do not use letters very much. We use stickers—first, second, third and fourth—on our


Dr. Manheimer


Mrs. Nelson


Mr. Vanderwarker


Mr. Jones

statements. We have these made up, and then the letters follow.

MR. JONES: Do you have a collection manager at Women's and Children's?

MRS. NELSON: No. In small hospitals they usually don't. We have two clerks in the accounts receivable department, and they follow up by telephone and write letters. We have also been very satisfied with our collection agency. We haven't had any reports of bad public relations, and we have collected accounts through them that we couldn't get ourselves.

MR. JONES: I think credit people generally recognize that there is a certain class of people who just won't take action until they get some kind of forceful follow-up from a third party that is really not part of the hospital. Then they begin to think it means business, and they will pay. I would like to go back to the very first step, when the patient is actually admitted to the hospital. How do you handle patients when they come in to try to get the collection problem reduced to a minimum at this point?

DR. MANHEIMER: We tell them that they are expected to pay one week in advance. Many of them are not prepared, and then we send them a bill within the first 48 hours.

MR. JONES: If you have a patient you know is probably a bad credit risk and he can't pay that week in advance, does the credit manager interview him right then and there?

DR. MANHEIMER: The patient himself is rarely interviewed. We run a very busy hospital, and practically every patient is an emergency, because we have such a long waiting list. We usually have the patient sent right up to his room, so it is a relative who gives the admission data and is told about the financial arrangement. The credit manager does not interview the relative or the patient on admission. He does it afterwards if there is some problem. The admitting clerk or the cashier is the person who takes the first step.

MR. JONES: In other words, the rule is to take care of the patient first, and find out about the money afterwards?

DR. MANHEIMER: That is what I wanted to bring out. The patient must be taken care of first.

MR. VANDERWARKER: We do the same thing and simply ask for payment a week in advance.

MR. JONES: What if they don't want to pay a week in advance?

MR. VANDERWARKER: Then it is referred to the credit manager, and she follows up.

MR. JONES: But does the credit manager interview the patient before he is admitted?

MR. VANDERWARKER: No. What would be the point? We know we are going to admit those people to the hospital. They are sick. There is no question about whether they should or should not have hospital care. The question is about their ability to pay.

MR. JONES: Suppose the patient who presents himself for admission is known to be a bad credit risk and is coming in for elective surgery. You have issued instructions to collect a week in advance from that patient, and he won't pay. Will you still let him in?

MR. VANDERWARKER: No, but those cases are extremely rare. If it is elective and you definitely know he is a bad risk, that is simply a credit problem. But let me emphasize that those cases are so rare that they never really occur. Such a case has never come to my attention.

MR. JONES: They are not rare in many hospitals in the country. Many patients are just bad credit risks. They shop from hospital to hospital, and something has to be done to stop that kind of patient from taking money away from hospitals.

DR. MANHEIMER: Elective cases in our hospital usually come in after a four to six weeks' wait. The doctors know of our policy and tell their patients that they have to be prepared to pay a week in advance, and over a period of four to six weeks, they usually can manage to save up enough to pay that much money.

MR. JONES: Do you have any material that you give the doctors to hand out to patients to explain the credit problems and policies and give your rates, so that they know what to be prepared for?

DR. MANHEIMER: We have in two instances, obstetrics and tonsil cases, which are so-called flat rates.

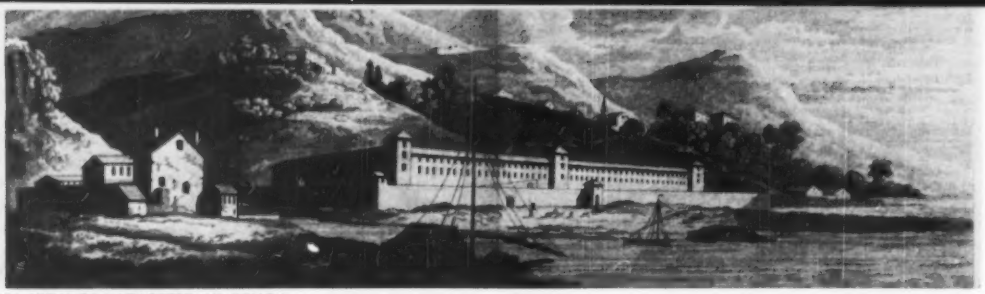
MR. VANDERWARKER: We don't have any printed material, but our doctors know our policy and our rates, and if there is any question in their minds, they make it very clear to their patients and try to estimate their hospital bills. We have quite a good-sized information booklet that we give to patients, but that is given to them at the time they arrive.

MRS. NELSON: We keep after the doctors, I mean our bookkeepers do, and at the end of every six months we show the doctors how many bad debts their patients have outstanding, and they really take quite an interest. The doctors work hard when they see that we are being gypped, and there is a little rivalry there to see who has the fewest bad debts in the house.

MR. JONES: Here is a scheme I have seen work successfully in several places. The hospital's admitting and credit departments work with the doctors to get advance notices of reservations on patients who aren't strict emergencies, so the credit department can check back to see if the patient has been in before and what the credit experience was, and if necessary buy a credit report. In many towns of 100,000 population or less, you can get credit reports on almost anybody on an hour's notice. With advance notice on reservations, the hospital can get all the credit data together and then instruct the admitting officer how to handle each particular patient from a credit standpoint. Doctors often wonder about the patient's credit standing, and this information might help them decide how much they ought to charge. If the hospital opens its credit facilities and information to the doctors, they should reciprocate by being careful to give advance reservations whenever possible.

DR. MANHEIMER: That is fine, but that is applicable only to hospitals with many reservations in advance. In an

(*Continued on Page* 124.)



SEA VIEW OF LAZARETTO AT GENOA

THEY MADE HOSPITAL HISTORY

JOHN HOWARD

By OTHO F. BALL, M.D.
President, The Modern Hospital Publishing Company, Inc.

THE modern hospital with its sanitation and order, its well equipped laboratories and operating rooms, its diagnostic and therapeutic equipment, its well trained medical and nursing staffs, and its efficient management seems far removed from the wretched hospitals of a century and a half ago. A few of these hospitals were fairly well organized but in most of them the dark, unventilated, unheated rooms reeked with filth and vermin. The patient lay untended upon a sanded or straw-littered floor, unbathed and covered with rags. Today this seems only the imaginings of some fiction-writer. Yet these are the conditions John Howard (1726-1790) observed and exposed. Fortunately he lived to see the beginning of the great reform. Brown, his biographer, calls him one of the greatest men the world has ever produced.

He is best known for his great prison reforms, an interest that came through a strange experience. On his way to Lisbon, ruined by an earthquake in 1755, his boat was seized by pirates. After 40 hours without food or water, the prisoners were taken to a castle in Brest and confined in a dungeon where they lay for six nights on a dirty floor, with nothing to eat but a joint of mutton tossed to them. Paroled, Howard returned to England determined to examine the prison system there. When as High Sheriff he had to visit the jails he was shocked at the scandalous conditions he observed. He began an extensive tour through the prisons of the British Isles and reported to the Parliament the vile conditions he observed. His shocking revelation brought in 1774 a vote of thanks from the House of Commons.

This was the beginning of Howard's 17 year work of reform ended only by his death. Howard visited prisons across the continent of Europe and into Asia Minor, giving alms to the unfortunates, for it was the only way he could gain entry. Then with meticulous care he prepared his illuminating book, "The State of Prisons," reporting each prison he had visited and awakening the world to the inhuman conditions in which these forgotten men were living. As Aikin (1812) pointed out, Howard was fortunate in having the benefit of a free press so that he was able to present this miscarriage of justice to the public.

Meanwhile on his many trips Howard had noted equally vile conditions in the hospitals, particularly in his tour of England. These he exposed in his 1780 appendix to the "State of the Prisons in England and Wales" and contrasted these hospitals with some of the poorest and best ones he had seen in Europe. He found the London Hospital in Whitehall without water cisterns, the vaults offensive, the medical and surgical patients unseparated, the rooms low-ceilinged and dirty, the windows tightly closed, and only one bath in a dirty cellar, and that rarely used. The scanty diet contained no vegetables.

Guy's Hospital was infested with bugs; the men's ward of St. George's Hospital was particularly offensive. The hospitals of Ireland were filthy, the furniture was in disrepair and dirty, proper beds and bedding were lacking, the water supply was bad, no baths were available, the sewers poor, toilets defective, and the food was extremely poor. It was not an uncommon experience to find a patient lying in clothes which had not been removed for a fortnight, or a ragged patient tearing up his shirt to bind his wounds.

His great exposé of conditions came with his publication of "An Account of the Principal Lazarettos in Europe, With Various Observations on Some Foreign Prisons and Hospitals and Additional Remarks on the Present State of Those in Great Britain and Ireland." This large volume minutely described conditions of these lazarettos erected in important ports to care for and isolate seamen arriving at these ports. Howard also revealed conditions as he found them in inland hospitals, each hospital described in detail, good or bad. It was such a revealing volume that it shocked all Europe. In 1785 he began a pilgrimage through France and Italy, interrogating physicians along the way. Not getting satisfactory replies, particularly regarding the cause of the plague then raging, he went on until he reached Smyrna and Constantinople.

Everywhere Howard went he found hospitals in the same disgraceful state. His description of the hospitals he visited throughout the British Islands

brought astonishment and dismay. The hospital at Maryborough in Ireland was an old house with four rooms having black filthy walls. An upper floor had two rooms with 13 beds containing 15 patients. A tower room held two patients without beds except for some hay on the floor which was reserved for the nurse. There was no water or vault in the building. The six by 10 foot surgery contained as equipment 10 vials, some uncorked, a little salve stuck on a board, some tow, and pieces of torn paper scattered on the floor. The Cavan County Infirmary of Ireland, with its four men and three women patients, consisted of dirty rooms with little or no bedding; the upper room was filled with chickens; the small front court contained a dunghill.

Always with his condemnation of the loathsome conditions of the hospitals, Howard presented plans for building sanitary hospitals and their regulation. Many of these proposals were similar to those presented later by Florence Nightingale. It has been said that Howard prepared public opinion to receive her suggestions. He presented plans for proper ventilation of the rooms, sanitary measures, good water supplies and sewage, bathing facilities, and general delousing of bedding and rooms. Many of his recommendations were followed in various communities, and in his books Howard pointed out success or failure in following his instructions since he had paid his last visit.

Howard was one of the few reformers who lived to see his reforms inaugurated. He also lived to receive honors and acclaim from the peoples of Europe. Following his death, a statue was erected in St. Paul's Cathedral. The inscription says, in part, "This extraordinary man had the fortune to be honored whilst living, in the manner which his virtues deserved. He received the thanks of both Houses of the British and Irish parliaments for his eminent services rendered to his country and mankind. Our national prisons and hospitals, improved upon the suggestion of his wisdom, bear testimony to the solidarity of his judgment and to the estimation in which he was held. In every part of the civilized world he traversed to reduce the sum of human misery, from the throne to the dungeon, his name was mentioned with respect, gratitude and admiration. His modesty alone defeated various efforts that were made during his life to erect this statue which the public has now consecrated to his memory."

Every modern hospital stands as a memorial to this great man.

Music With Their Meals Makes Patients Happy

AN EASY and inexpensive way to entertain patients at mealtime and other periods during the day has been worked out at the Kensington Hospital, Philadelphia, where the loud-speaker system used to page doctors does double duty by carrying music to the floors, dining and service areas. The music originates with a record player installed at the switchboard within easy reach of the telephone operator, who handles the musical programs nicely along with her regular work.

"The volume is kept at a soft level," James C. Terry, hospital administrator, explained, "so when it is necessary to use the public address system for announcements or paging during the music periods the microphone can be used over the system without stopping the music."

Mary Kehan, nursing director, makes the musical selections, and a survey of patient opinion after music had been played for several days revealed a strong preference for vocal selections and for popular and semi-classical music. Without exception, patients queried said they liked the music and added that it helped them relax. Most of them liked the subdued volume and thought the musical interludes shortened the hospital day, though a few said crisply that it didn't make any difference to them.

Besides one woman patient who said flatly that she wanted Italian opera, and no nonsense about it, the only criticism in the early days of the programs came from the surgeons, who said the music was distracting and asked for a switch that would cut off the loud-speaker in surgery during the musical periods. This was installed right away, Mr. Terry reported.

The entire installation, including 15 outlets covering all floors of the hospital, an amplifier, microphone and 45 r.p.m. record player, was a gift to the hospital from a member of the board of trustees, Mr. Terry said.

John Auspitz, board member who donated the installation, explains to Mrs. Mary T. Kehan and James C. Terry exactly how the system operates.

How the small hospital can achieve an

EFFICIENT SUPPLY SYSTEM

HAROLD E. FRYE
Purchasing Agent, Chambersburg Hospital, Chambersburg, Pa.

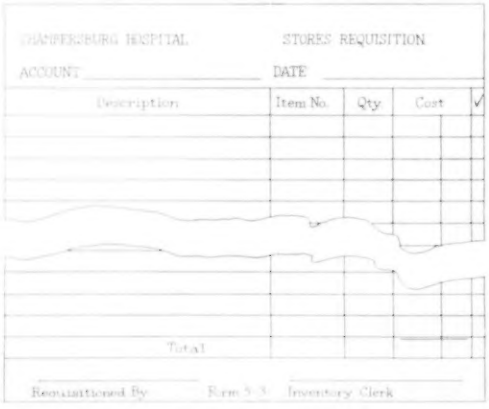
ADEQUATE supplies and supply rooms are important to any hospital. Lacking either, no hospital can function properly. It is of great importance to have an effective supply system that functions properly and gives the service required by all departments.

The supplies I purchase will not exceed at any time, regardless of price or quantity, the needs of a three-month period, nor will they be less than the requirements for one month. I do this because I believe that money spent on supplies that do not revolve in a period of three months is lost owing to the fact that we are unable to purchase other necessary items because of insufficient funds. Also, there will be a tremendous amount of unnecessary money spent on items which are not needed in such large quantities. There are always exceptions to these rules.

Nevertheless, even for a small hospital, it is of paramount financial importance to observe three items in the matter of purchasing. These are: the hospital discounts; the advantages of multiple over single purchases, and the advantage of wholesale over retail purchases. The purchasing agent of a small hospital should persistently attempt to obtain hospital discounts on all purchases. These are frequently available but often only when they are consistently requested. Likewise, the hospital that is often forced to buy single items, or when these must be obtained from local retail sources, will find itself placed at a serious financial disadvantage. Purchases based on hospital inventory lists which will carefully avoid multiple trade name items, if obtained through major supply sources, will usually avoid these latter disadvantages. Sometimes it is of great advantage to make purchases outside the medical trade circles. Similar items can frequently be found at lower prices in the catalogs and sales literature of general supply sources.

One of the most helpful and essential procedures connected with purchasing and supplies control is the perpetual inventory, which is kept by either the supply clerk, the accounting office, or, as in my case, the purchasing agent. This inventory, to be accurate, should contain the following information on a special inventory card: (a) description of item; (b) item number; (c) size of item, (example: "4 oz. grape jelly"); (d) on order; (e) disbursed quantity and value; (f) received quantity and value, and (g) the unit price. With this information one is able to answer any question that may arise, assuming that the files are kept as accurately as possible. This is achieved by requiring all items to be dispensed only on receipt of a requisition properly written and signed by the head nurses of the respective floors. It is wise to have special days set aside to fill or-

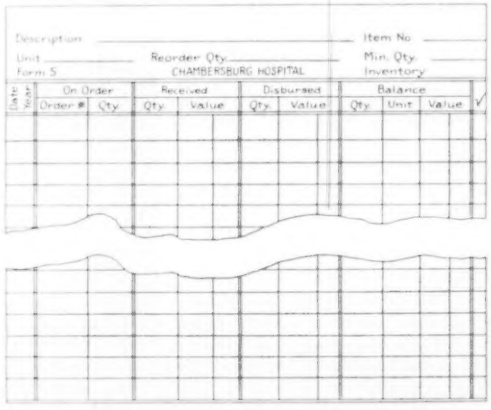
Below, left: The stores requisition form shows description, item number, quantity and cost. Right: Inventory card is essential to supplies control.


CHAMBERSBURG HOSPITAL STORES REQUISITION

ACCOUNT _____ DATE _____

Description	Item No.	Qty.	Cost	✓
Total				

Requisitioned By _____ Form 5-S Inventory Clerk


Description _____ Item No. _____

Unit _____ Reorder Qty. _____ Min. Qty. _____

Form 5 CHAMBERSBURG HOSPITAL Inventory

Date	On Order		Received		Disbursed		Balance			✓
	Order #	Qty.	Qty.	Value	Qty.	Value	Qty.	Unit	Value	

ders, such as Wednesday for first and third floors, Thursday for housekeeping, and so forth. This will obviate excessive traveling to and from the supply rooms. It also will help the stock boy inasmuch as he will not be rushed as he would be if all orders were sent down in one day.

A properly filled requisition should contain the description of the item wanted, the quantity and the item number which is obtained from an inventory book listing all the items in alphabetical order and containing their respective numbers. All the department heads should have copies of the inventory book. Such an inventory book also will avoid multiple name items. After the requisition has been filled, it should be checked off item for item from the inventory card, and the cost should be written after each item; the requisition should then be sent to the accounting office.

PURCHASE ORDER IN TRIPLICATE

The system I use in ordering is highly effective. I use a triplicate copy of the purchase order, all three copies of which contain identical numbers. The type of purchase order I especially like and use contains the hospital's address, the order number, a blank space for the sales company's name, one column for quantity, one wide column for description, and one column for the price. One copy is given to the company, one goes to the accounting office and the last copy is sent to the stock room where the receiving is done. It is there put on file to await the receipt of the order. All orders given must have a purchase order signed by the administrator and the number of the purchase order must appear on all orders received. Upon receipt of the order it is stamped with a rubber stamp as follows: (a) quantity, O.K.; (b) quality, O.K.; (c) price O.K.; (d) ledger charged, and (e) date received. The order and the supplies are then taken to the department for which they were ordered and then the department head fills in the spaces that have been stamped. If they go to the supply room direct, the clerk should complete the receipt form and give it to the person in charge of the file. This person should have a knowledge of general supplies, such as household, dietary, surgical, drugs and intravenous solutions. The best way to obtain this knowledge is by actual experience and hard work. Attending hospital conventions also is helpful.

Before any supply room will function properly there must be cooperation from all department heads, doctors, nurses and everyone who has anything to do with supplies. The purchasing and stores department must give cooperation also. It takes teamwork to operate.

In concluding, I would like to say something concerning the interviewing of salesmen. Seldom during my time of interviewing salesmen have I ever refused to give them at least a few minutes of my time, even though it may be only long enough to explain why I cannot see them or to arrange another meeting. Interviewing is an important part of any purchasing agent's job. To me, salesmen are like an additional man in the supply room, helping me to obtain top quality articles at the lowest possible price. This is another example of teamwork in which both hospital and salesmen will benefit.

The Modern Hospital Gold Medal Award

Ray E. Brown

Dr. J. T. Morrison

Ray E. Brown, superintendent of the University of Chicago Clinics, and **Dr. John T. Morrison,** medical director at Charleston, W.Va., for the United Mine Workers Welfare and Retirement Fund, were named co-winners of The MODERN HOSPITAL'S Gold Medal Award for contributions to the hospital literature of 1949-50.

The awards were made for Mr. Brown's article, "Hospital Tensions Threaten Tenure," appearing in The MODERN HOSPITAL for November 1949, and for two articles by Dr. Morrison which appeared in the March and April 1950 magazines under the title, "Small Hospitals as Centers of Medical Education."

The committee of the editorial board that made the awards recommended that **Elisabeth C. Phillips, R.N.,** be given Honorable Mention for her article "A Practical Plan for Education of Practical Nurses," which appeared in May 1950. Miss Phillips is executive director of the Visiting Nurse Association at Rochester, N.Y.

The awards are made annually on the basis of originality of the ideas embodied in contributions to the magazine, their applicability throughout the hospital field, and the quality of the presentation. The committee reviewing contributions and selecting the winners consists of Dr. Arthur C. Bachmeyer, chairman, Dr. Basil C. Mac Lean, Dr. Robin C. Buerki and William J. Donnelley, all members of The MODERN HOSPITAL'S editorial board.

Mr. Brown's prize-winning article spoke out frankly and critically on a delicate subject — administrator-trustee relations. Lack of understanding of one another's functions is the chief cause of conflicts resulting in rapid turnover among administrators, Mr. Brown stated. "The hospital trustee-administrator relationship is subject to extraordinary tensions that are not common to other types of enterprise," the article stated. "The existence of these tension areas is too often not recognized by either party." Involvement of board members in administrative details and administrators in policy-making board functions are practices that contribute to conflict, Mr. Brown said. "The responsibilities of a hospital trustee are large," he concluded, "and so are those of a hospital administrator. The largest responsibility of both, however, is to understand the rôle of the other."

Developed from studies made when he was associate director of the rural hospitals division of the Commonwealth Fund, the articles by Dr. Morrison described a program of regional affiliation which would make it possible for small hospitals to offer more comprehensive medical service, keep abreast of the medical times, make available to medical students a new wealth of clinical material, and become an integral part of medical school activity.

The Honorable Mention article by Miss Phillips warned that when nursing functions are turned over to auxiliary workers, jobs must be carefully defined so that workers will know what their jobs are and what they are not, and so that doctors and professional nurses will know what training each auxiliary group has had.

About People

Administrators

Dr. Karl S. Klicka, director of Woman's Hospital, New York City, since December 1945, has resigned that position to become director of St. Barnabas Hospital in Minneapolis. He will assume his duties there on January 1.

Dr. K. S. Klicka

D. M. Morgan

Dorothy M. Morgan, acting superintendent of St. Barnabas since the resignation of **George J. Bartel** in July, has been appointed superintendent of the hospital. Miss Morgan received her M.B.A. degree in hospital administration from the University of Chicago in 1949 and became associated with St. Barnabas Hospital as assistant superintendent in July 1949.

Ralph R. Betts, an administrative assistant of Glens Falls Hospital, Glens Falls, N.Y., for several years, has been appointed assistant superintendent. Other new appointments at Glens Falls are those of **Albert J. Francato** as purchasing agent and **Elizabeth F. Dube** as head of the dietary department.

Sister Catherine has been named administrator of the new Dubois County Hospital, Jasper, Ind. She was formerly associated with Little Company of Mary Hospital, Evergreen Park, Ill.

Ethel Ewing has resigned as administrator of Dukes-Miami County Hospital, Peru, Ind. Miss Ewing is retiring from the hospital field.

Sister Mary Rosalia, R.S.M., has been named superintendent of Mercy General Oklahoma City Hospital, Oklahoma City, Okla., to succeed **Sister Mary Madeline,** who has been transferred to a hospital operated by the Sisters of Mercy in Kansas.

Lillian E. Van Pelt, R.N., for more than 40 years superintendent of Marshall Lodge Memorial Hospital, Lynchburg, Va., retired on October 1.

Delbert L. Price has been named administrator of Children's Memorial Hospital, Chicago, to succeed **Mabel W. Binner,** whose resignation was reported last month. Mr. Price is a graduate of the University of Iowa, where he received the degree of bachelor of science in commerce. In 1947 he was graduated from the University of Chicago with the degree of master of business administration in the field of hospital administration. At present he is assistant superintendent of Butterworth Hospital, Grand Rapids, Mich. He will assume his new duties at Children's Memorial on January 1.

G. O. Lindgren, business manager of the University of Kansas City, Kansas City, Mo., has accepted the position of administrator of Trinity Lutheran Hospital, Kansas City.

Ruth Brant was honored recently with a testimonial banquet on her 25th anniversary as superintendent of Martins Ferry Hospital, Martins Ferry, Ohio. More than 300 persons attended the party, arranged by the woman's auxiliary to the hospital and the school of nursing.

David Constantine has been appointed assistant executive director of Lebanon Hospital, New York City. A graduate of Northwestern University, he served his administrative residency at Passavant Memorial Hospital, Chicago. Prior to that, Mr. Constantine was associated for a number of years with the Institute of Inter American Affairs, health and sanitation division, in Washington, D.C. He also served as administrative officer in the health and sanitation division in South America.

Marian Black has been named administrator of the Washington County Hospital, which is now being constructed at Salem, Ind. Miss Black was formerly in the hospital field in Alabama.

Dr. William W. Fellows, chief of the surgical service at the Veterans Administration Hospital at Aspinwall, Pa., has been appointed manager of the 1005 bed V.A. hospital now under construction at Albany, N.Y. Dr. Fellows has been in V.A. service since 1931. Previously he had spent six years in private practice at Salisbury, Mo.

Harl N. Stokes has been named administrator of the new Okfuskee County Hospital, Okemah, Okla. Mr. Stokes, former Blue Cross-Blue Shield representative of southeastern Oklahoma, assumed his duties at the hospital November 1.

Paul Nixon has been named administrator of Barre City Hospital, Barre, Vt., to succeed **Pat N. Groner.** A retired colonel of the U.S. Army, Mr. Nixon served as manager of the Santa Cruz County Hospital, Santa Cruz, Calif., for a period of about 18 months ending in May.

Frank H. Barrett, administrator of the Atlantic City Hospital, Atlantic City, N.J., for the last year, resigned November 1. **John E. Vanderklish** has been named acting director.

Fulton A. Grosse became comptroller and assistant to the administrator at McKinley Memorial Hospital, Trenton, N.J., on November 1. Mr. Grosse has been connected with army and navy hospitals for the last 10 years.

Melvin H. Dunn has been appointed director of the Church Charity Foundation, official medical and dependency center of the Episcopal Diocese of Long Island, N.Y. His appointment followed the resignation of **E. Reid Caddy,** director for the last seven years. Mr. Dunn was associated for 18 years with St. Luke's Hospital, Kansas City, Mo., where he became assistant director in 1944.

M. H. Dunn

Samuel Zibit, administrator of public health and medical care programs for the last 10 years, has been appointed assistant executive director of Miriam Hospital, Providence, R.I.

C. Douglas Auty has been named administrative assistant for personnel at Presbyterian Hospital, New York City. He will be responsible for employe relations among the 3000 salaried workers at the hospital.

(*Continued on Page* 150.)

no waiting..

FOR PLASTER TO SET

These new *EXTRA*-fast-setting bandages—latest addition to the "Specialist"* family of plaster-of-Paris products—will save time and eliminate irksome waiting for plaster to set in club-foot, wrist, ankle and other small casts. Order now through your dealer or write us for FREE trial supply.

*Trade Mark Johnson & Johnson

"Specialist"

EXTRA-FAST-SETTING

PLASTER OF PARIS

BANDAGES

Johnson & Johnson

NEW BRUNSWICK, N. J.

Conducted by Raymond P. Sloan

The first personnel party was a memorable affair, with turkey dinner, carols and grab bag presents for everybody. Service pins were presented to employes who have been with the hospital five or ten years.

Volunteers contribute to the

CHRISTMAS SPIRIT

ALMA M. TROXELL
Superintendent
Oil City Hospital
Oil City, Pa.

EARLY in December there are signs in Oil City Hospital, Oil City, Pa., that Christmas is coming and that the community is going to do its part in seeing that patients and staff have a pleasant one. Early, too, come strains of Christmas music from the nurses' residence. The students are rehearsing—a sign that the hospital isn't always to be on the receiving line, for several invitations have already come for the glee club to sing before civic and church groups during the preholiday season.

Caroling by the glee club is a yearly event for the December meeting of the Hospital Aid, and at the tea following the formal program the students have an opportunity to become acquainted with the representative women of the community. The Aid, too, gives a substantial sum to the hospital for Christmas decorations so that every window in the ward has a wreath and every patient department has a lighted tree.

Usually the holiday spirit has found expression in a series of small celebrations in the various departments, but in 1949 we held our first personnel party with an almost 100 per cent attendance. The committee representing all departments planned a truly memorable affair with a turkey dinner, grab bag, carols and a magician for entertainment. The highlight came with a surprise presentation of 10 year and five-year service pins—and, also a surprise—the presentation, appropriately enough of a large safety pin to the toastmaster for his one year of service! All present voted unanimously for another similar function next year.

A few days before Christmas the Gray Ladies of the local chapter of the American Red Cross take over the task of trimming trees and decorating the lobby while the maintenance department of the hospital places the outdoor decorations.

Meanwhile mysterious bundles for students and staff are piling up on Santa's shelf, and only those marked perishable get past watchful eyes. These are to be presented at the Christmas party which the faculty plans for the student nurses. Then, after a program of song and story, Santa arrives with gifts for all. His identity is a deep dark secret until some familiar act or word betrays him as a member of the medical or nursing staff.

The students have an opportunity in their turn to share the Christmas spirit with their patients and this is the most formal and colorful of all the activities. The Sunday evening before Christmas uniformed graduates and student nurses gather in the hospital lobby. Led by the superintendent and the director of the glee club they march two by two carrying lighted candles through dimmed corridors, and while the multicolored lights of the department's Christmas tree glow, they sing an appropriate carol: "Santa Claus Is Coming" for the children, "Away in a Manger" for the new mothers on the obstetrical floor, and end with an outdoor carol as a neighborly greeting. Patients and their visitors watch and listen with appreciation and delight. Christmas in the hospital might not be such a lonesome affair after all!

Other music is provided during the holidays by the Girl Scout carolers, and on Christmas morning the Salvation Army band plays in the hospital lobby, and at that time its captain brings a small gift for each patient.

All through November the members of the women's guild of the Second Presbyterian Church have been making red stockings, filling them with homemade candy, fruit and popcorn balls which will be distributed to the patients. On Christmas Eve about 6:30 o'clock Santa and his aide arrive at the hospital with sleigh bells jingling. Santa and the superintendent visit each patient, presenting the stocking with a smile of greeting or a word of cheer. Somehow the adults enjoy this even more than the children

Caroling by the nurses' glee club is a yearly event at the hospital.

do—who, of course, are overawed by Santa's august presence, or perhaps a bit disappointed that he didn't bring the other gifts he had promised when he made that special trip to the city during Thanksgiving week. These gifts will arrive in the morning, however, for Santa never forgets nor do the townspeople.

Sunday church school classes and Brownie troops have already brought scrapbooks or toys for the children's stockings while the Lions Club has evolved a unique plan for the members' entertainment at their pre-Christmas meeting. This features a grab bag of toys. These are meant primarily to be sent to pediatrics department for Santa—and each toy arrives there if it can still be operated after the member whose lot it was to draw it has exhausted its possibilities.

The dietary department serves the holiday trays with appropriate and colorful decorations. A lighted sparkler placed in a cup cake surprised the patients this year on Christmas Eve, and Sunday's breakfast tray carried a red rose provided by the Flower Mission—our oldest volunteer organization in point of service, with a 50 year record of providing flowers for the patients' trays each week, doing hospital sewing, and meeting every two weeks to do an endless amount of sewing for the hospital.

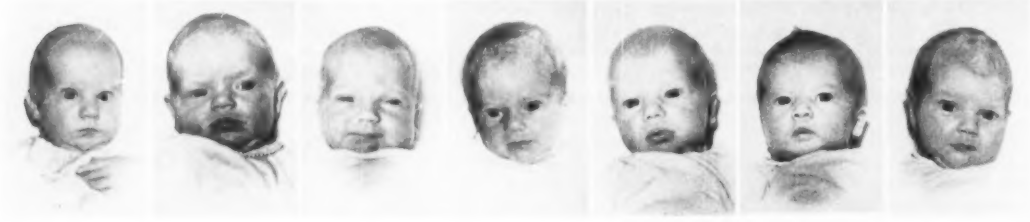
Noontime brings the turkey dinner —with favors provided by art classes of the public and parochial schools. If there is a patient far from home or if it seems probable that this will be his last Christmas, the superintendent invites a member of his family to have dinner with him as the hospital's guest. This is a courtesy the family long remembers.

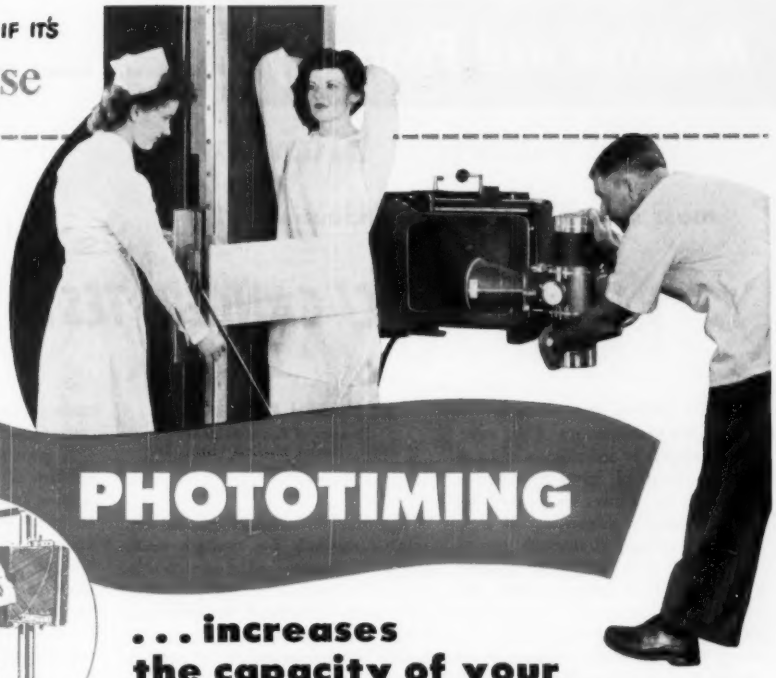
On Christmas night the busy festive season closes with a light supper and with an early bedtime hour for both patients and staff. Another Christmas has gone and with it another season of friendly cooperation between hospital and community.

Babies Alumni Association Raises Funds for Free Bed

THE Babies Alumni Association at Northwestern Hospital, Minneapolis, has been in operation for a little more than a year. The purpose of the project is to provide funds for a free bed in pediatrics. Eight hundred eighty dollars has been contributed to date and the amount is increasing each month. For example, we recently received contributions amounting to more than $100 during one month. Each mother receives a United States Government book "Infant Care" which has been dressed up with an attractive cover. Inserted in the book, mothers find an application form for the Babies Alumni which outlines the operations of the project and enumerates the benefits the mother receives when her baby becomes a member. For the membership fee of $5 the mother receives an official photostatic copy of the baby's birth certificate enclosed in an attractive leather folder, plus a photograph of the baby taken before the baby leaves the hospital.—DONALD C. CARNER, *formerly assistant administrator, Northwestern Hospital, Minneapolis.*

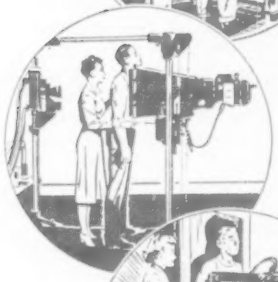
Below are a few members of the alumni group, which thus far has contributed more than $800 to the fund for a free pediatrics bed.





PHOTOTIMING

. . . increases the capacity of your radiographic facilities



Past experience has proved that the use of Westinghouse Phototimers can at least double the number of patients your present facilities will handle.

Westinghouse offers a *complete* line of phototimers for every radiographic purpose. Now, even more, you can be SURE of your techniques. With but simple settings, Westinghouse Phototimers assure you of:

1. Films of constant density, regardless of part thickness or pathology.
2. Fewer retakes.
3. Proper timing under all conditions.
4. Conservation of your time.

Call your local Westinghouse X-Ray Representative to learn how phototimers may be added to your present equipment or included when you purchase new apparatus. Or, if you wish, write to Westinghouse Electric Corporation, 2519 Wilkens Ave., Baltimore 3, Maryland. J-08234

Westinghouse
X-RAY

mass survey method of conducting

GASTRIC CANCER TESTS

JOSEPH B. KELLY
Director of Public Relations
Johns Hopkins Medical Institutions
Baltimore

A NEW method of conducting mass survey examinations of the stomach, developed by radiologists at Johns Hopkins Hospital, gives promise of providing the answer to one of the most pressing problems in the fight to save victims of stomach cancer.

The method is designed to examine large population groups quickly and inexpensively in an effort to discover gastric cancer in its early stages before it has progressed to a point where treatment is relatively hopeless.

The Hopkins doctors are using small-film photofluorographic methods for the first time in x-ray examination of the stomach although similar technics have been extremely successful in mass population chest x-ray examinations for the early detection of pulmonary tuberculosis.

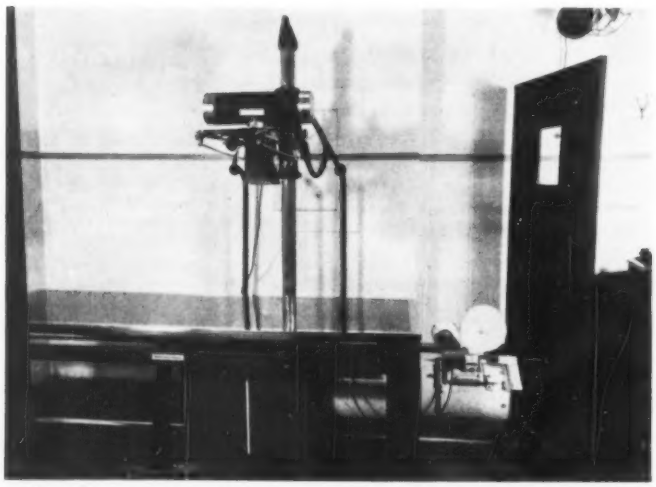
The use of ordinary photofluorographic methods for stomach examination has been looked upon with some skepticism because of the excessively large doses of radiation that previously have been necessary to produce satisfactory photofluorograms of the abdomen and also because of the unknown efficiency of this method in the early detection of gastric abnormalities.

By adapting Schmidt optics—a photo principle involving the use of mirrors instead of lens—it is now possible to obtain satisfactory miniature films of the stomach with little more radiation than that required for conventional x-ray.

A pilot study to determine the reliability of diagnosis by this method is now in its third year at Hopkins and will be continued for five years under the direction of Dr. Russell H. Morgan, professor of radiology at Hopkins Medical School and radiologist-in-chief at the hospital, Dr. John F. Roach, associate professor and radiologist-in-charge, and Dr. Robert D. Sloan, assistant professor and staff radiologist.

The need for earlier diagnosis of gastric cancer is strikingly illustrated by latest available data on the disease. Morbidity and mortality statistics reveal that approximately 60,000 men and 42,000 women over the age of 40 develop gastrointestinal malignancy each year in the United States. Of the various types of malignancy occurring in the alimentary tract, cancer of the stomach is the most prevalent. In men, 40 per cent of malignancies of the digestive tract are gastric in origin. In women, 30 per cent of such lesions lie within the stomach. Latest statistics show that the average length of life following the recognition of stomach cancer is one year and eight months regardless of therapy.

Therapeutic procedures used in the control of gastric cancer have been radiological and surgical. The first has been uniformly unsuccessful because of the high resistance of gastric neoplasms to any of the radiations that have been available to date. Despite the advances in surgical and anesthesia technics and the improvements in preoperative and postoperative care, the record of surgical treatment has also not been very satisfactory. This is because in all but a distressingly small percentage of cases, the malig-



Photofluorographic unit for mass roentgenography of the stomach.

nancy has progressed so far when the diagnosis is made that either it is totally inoperable or else the patient can receive only temporary benefit from surgical intervention.

Efforts to obtain earlier diagnosis have been and are still being made through nationwide educational programs designed to warn layman and physician alike of the cancer problem but it is thought unlikely that such a program alone will materially affect the gastric cancer death rate. This is due to the fact that gastric malignancy in its early and potentially curable stages is usually relatively asymptomatic. This has been demonstrated in the cases of several prominent physicians who although thoroughly conscious of the problem were unable to recognize their own symptoms and subsequently died from cancer of the stomach.

DANGER TO FLUOROSCOPIST

At the present time, x-ray examination of the stomach offers the best hope of obtaining earlier detection of the disease. Standard x-ray procedures, however, combining both fluoroscopy and films are slow and need the prolonged services of highly trained physicians. In large scale examinations under this method, there is distinct probability of permanent radiation damage to the fluoroscopist. In addition, conventional x-ray requires the exposure of films of large size which are impractical for mass examinations not only because of the initial cost but because of expense of time and money in handling, processing and storing.

Because of its successful use in mass chest examination, photofluorography appeared to give the most promise in developing a method not only to find those individuals in the general population who despite apparent good health and lack of symptoms have a gastric malignancy or its precursors but also to conduct periodic check-ups on those individuals in the susceptible age group.

With the use of Schmidt optics the problem of excessive radiation in photofluorography has been overcome. A 70 mm. Schmidt camera, constructed by the Danish engineer, Helm, is the nucleus of the new equipment. This camera has an f/ number rating of 0.75 and has a speed approximately five times greater than that of photofluorographic cameras commonly in use. Measurements of

resolving power made at the National Bureau of Standards indicate that the ability of the camera to record detail is equal to that of conventional cameras using 70 mm. film, in spite of its speed.

The high speed of the camera is achieved by virtue of the unusual optical system in which the principal lenticular element consists of a large spherical mirror which picks up the light from the fluorescent screen and reflects it directly on the photofluorographic film. Because the aperture of the mirror is much larger than that which can be attained in lenses of the conventional refractor type, the proportion of the light delivered to the film from the screen is greater than in ordinary lenses.

With the new equipment only six minutes per person is required to make the examination and no special advance preparations on the part of the patient are necessary, for the patient does not have to undress. A small cupful of a barium, water and chocolate malt mixture is given to the patient to drink and a total of six films, all in the recumbent position, is taken. The films can be developed and read rapidly and cost only a fraction of those used in the conventional examination.

A preliminary report after 6000 patients had been examined at Hopkins shows that 91.7 per cent of the tests were satisfactory for screening purposes—that is, were felt to be adequate in determining whether or not the stomach was normal; 8.3 per cent of the examinations were considered unsatisfactory for diagnostic purposes.

Chief causes of the unsatisfactory tests were found to be due to difficulties of a technical nature, excessive food in the stomachs of some patients, and marked obesity in a relatively small number, a condition which makes it difficult to obtain satisfactory x-rays of the abdomen even by conventional methods. In regard to the failures because of excessive food, the

radiologists pointed out that no special means were taken to have any patients in a fasting state as is usual in standard gastrointestinal examinations.

Of the satisfactory examinations, 83.2 were considered to be normal and 8.5 per cent abnormal. As a standard of comparison for the new procedure, the conventional x-ray examination of the stomach, consisting of both fluoroscopy and films, has been adopted and all those considered abnormal as well as a number of those adjudged normal were requested to return for standard fluoroscopic and roentgenological gastrointestinal study.

Of 442 patients declared normal by photofluorographic test, the conventional examination confirmed the finding in 433 cases. Nine cases showed an abnormality of the stomach which was not discovered by the new method but all of these had insignificant lesions of a benign nature.

One hundred seventy patients who were declared abnormal by the new test were found to be normal under conventional studies. Although this may seem to be a high negative error, the doctors pointed out that error of this kind was expected since any irregularity on the photofluorographic films was called abnormal until proved otherwise. It should be clearly understood, the Hopkins doctors point out, that the photofluorographic method is a screening procedure only, and that final evaluation of suspicious cases must await conventional radiologic study.

There were 81 cases in which abnormality was detected by the new procedure and confirmed by conventional examination; 23 were cases of gastric malignancy that have since been microscopically proved and there were 13 in whom malignancy was suspected but has not yet been proved microscopically. The remainder were found to have various benign lesions.

Of the 13 in whom gastric cancer is suspected but not yet proved nine were symptom-free individuals who had no complaints related to the stomach. Of the other four, one has marked symptoms, one has moderate symptoms, and the other two have mild symptoms.

PATIENTS HARD TO CONVINCE

According to the doctors, a rather unusual situation has arisen from conversations with the symptom-free patients. They have found it impossible to convince any of those who feel well that he needs an operative procedure of the magnitude of gastric resection. These patients are being reexamined frequently, however, and it is felt that it may be possible to study the development of gastric cancer in the presymptom stage to an extent that heretofore has not been possible. The Hopkins group feels that if further studies bear out the initial data, many concepts regarding the development of gastric malignancy will require change.

In conjunction with the Hopkins study, a photofluorographic machine of the same type has been installed at the du Pont plant in Wilmington, Del., and it is planned to have all workers over 40 undergo periodic examination. It is hoped that further data on the rate of growth of gastric cancer will be obtained in these tests.

Other machines with the Schmidt optic unit are now in operation at Memorial Hospital, New York City, and Jefferson Hospital, Philadelphia; and in North Carolina, the State Health Department has installed one on a bus and is conducting examinations in all large population areas.

NEW

EFFICIENT

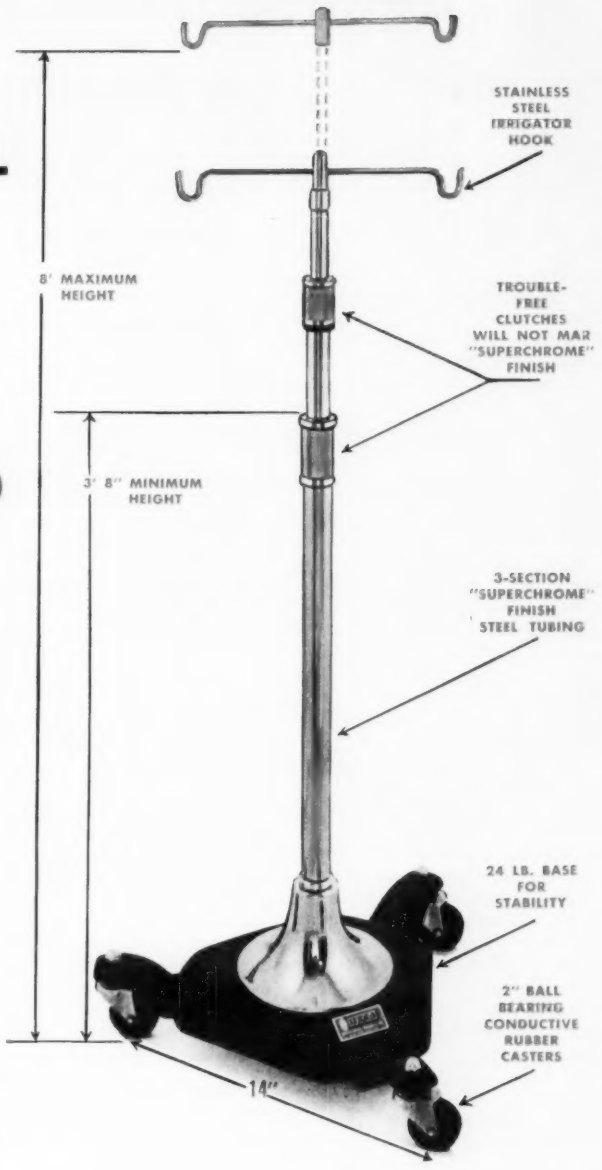
ECONOMICAL

IPCO
3-SECTION
I. V. STAND

. . . years ahead of the market in beauty, functional design and low cost.

But—you must see and work one of these stands to really appreciate what IPCO's engineering staff has accomplished in this important field.

Order one on approval. If you are not entirely satisfied in every way, you may return it for full credit.



EACH

1 to 5 . . . $24.95

6 or more . . 22.95

F.O.B. NEW YORK

INSTITUTIONAL PRODUCTS CORPORATION

161 SIXTH AVENUE · NEW YORK 13, N. Y.

Inapparent Salmonella Infections in Hospitals

JOSEPH FELSEN, M.D.
Director of Laboratories
ALFRED J. WEIL, M.D.
Bacteriologist
and
WILLIAM WOLARSKY, M.D.
Epidemiologist
Bronx Hospital
New York City

THE prevention and control of intramural outbreaks of enteric infection in hospitals is a source of considerable concern. Outbreaks have occurred with alarming frequency in even the best institutions. The general pattern appears to be the same in all cases. An infected food handler or a person with inapparent infection among the patients or nursing personnel is usually the source. The types of enteric infection most frequently encountered are those due to Shigella (bacillary dysentery) or Salmonella strains.[1] A few representative examples are an outbreak due to Bacterium Flexneri type 6 in a large, modern hospital in New York City;[2] a meningitic type of Salmonella havana in Havana, Cuba,[3] and Salmonella infections transmitted from mother to new-born child in hospitals in New York City,[4] New Orleans[5] and Australia.[6]

Six cases of Salmonella infection were detected within a short period in the course of routine epidemiologic surveys at the Bronx Hospital. They are reported in some detail because of their clinical, bacteriologic and epidemiologic implications. All were inapparent infections. One occurred in a nurse on the pediatrics ward, three in kitchen employes, one in a parturient mother, and one in a surgical patient admitted for treatment of a perirectal abscess. It is obvious at once how important these observations were, as all were capable of initiating an outbreak of Salmonella disease with subsequent potential fatalities, particularly among the newborn infants and the postoperative patients.

The newborn are particularly susceptible, since they appear to receive no immunologic protection from the mother. Protective antibodies against Shigella infections have not been demonstrated in the newborn. In Salmonella disease a similar conclusion is based on clinical rather than serologic grounds. With the 150 or more recognized strains of Salmonella and a high type-specificity of immunity, effective protective antibodies in the newborn are unlikely. Several years ago a mother was admitted in labor to the obstetrics service and was delivered of a normal, full-term infant within a few hours. At the time of her admission the mother had a low grade fever which was not considered significant. The day after delivery she had mild diarrhea, and blood as well as fecal culture revealed Salmonella paratyphi B. The infant soon exhibited identical clinical and bacteriologic symptoms and died within a few days. In order to close such a gap in our control work we have now instituted fecal cultures of all obstetric patients immediately on their admission. The value of such a precaution will be illustrated by the detection of a typhoid carrier (case 6).

REPORT OF CASES

Case 1.—T. A., a white woman, aged 22, a nurse in the pediatrics ward, had no history of previous intestinal disturbance. A sister who lived with her suffered with cramps and diarrhea, later found by us to be due to amebiasis. On Nov. 2, 1948, a stool submitted by the nurse for the usual monthly examination was found to be positive for Salmonella montevideo. The nurse was at once removed from duty with full pay, a measure found to be of advantage in having hospital personnel report diarrheal disturbances without fear of economic reprisal. Repeated stool cultures were made during the next 24 days; and three more stools were positive and four negative before three consecutive negative stools were finally obtained one month after the first positive culture. Since then repeated monthly stools have been negative for a period of 14 months, and the nurse has been working at her usual post. On Dec. 15, 1948, a test for circulating antibodies against S. montevideo was negative. In January 1949, because of complaints of right upper abdominal quadrant distress, a gallbladder roentgenologic series was done and reported as negative. A duodenal drainage on Jan. 4, 1949, was negative for Salmonella organisms. At the time when the first culture was positive (Nov. 2, 1948) sigmoidoscopy did not reveal evidence of intestinal disease.

Case 2.—M. R., a man aged 30, a Puerto Rican cook, during routine stool examination on Oct. 11, 1949, had a positive stool for Salmonella tennessee. It was found that this employe had had fever, diarrhea, nausea and back pains several days previously. These lasted 48 hours, during which time he had not reported for examination. He had eaten in various small lunchrooms in the vicinity of his home before the onset of symptoms. This type of restaurant in his particular neighborhood is usually not too clean or too busy, so that food might be kept for several days under unhygienic conditions. At the time the stool was submitted the employe had no medical complaints. There then followed five positive stools during the next three weeks before three consecutive negative stools were obtained. Because of this the patient was treated with chloramphenicol (chloromycetin) for three days, November 3, 4 and 5. All subsequent stools were negative. On Oct. 19, 1949, one week after the first positive

This article is an adaptation of that which appeared in the Journal of the American Medical Association, 143:1135, (July 29) 1950. It is reproduced with the kind permission of Dr. Austin Smith, editor, A.M.A.

stool and approximately two and one-half weeks after the gastrointestinal upset, sigmoidoscopic examination of the patient was carried out to a distance of 25 cm. There was no evidence of lymphoid hyperplasia or ulceration. The mucosa was slightly reddened and covered with some mucus. The exudate was normal.

Case 3.—M. A., a Negro, aged 30, a food server, during routine stool examination had a positive stool for S. tennessee on Oct. 11, 1949, the same day as in case 2. There was no history of intestinal disturbance. Subsequent stools were negative, and the employe returned to work by the end of the month. Sigmoidoscopy on October 19 was carried out to a distance of 25 cm. In the rectosigmoid there was seen the characteristic lymphoid hyperplasia with diffuse mucosal hyperemia and perinodular vascular congestion. Although this patient had but one positive stool with no intestinal symptoms, the sigmoidoscopic observations were typical for acute salmonellosis.

Case 4.—O. B., a Negro employe aged 28, had a positive stool for S. tennessee on Oct. 30, 1949. Because of cases 2 and 3 it was suggested by the hospital epidemiologist that another routine survey of stools be made before the usual time in order to see whether any new cases or carriers would be revealed. This additional case was found in an employe who worked in the baby formula room, a site of great importance. Three days after the stool was reported as positive the employe, who had been removed from duty, had an episode of nausea and vomiting lasting for 24 hours. All stools after the first were negative. This patient did not submit to sigmoidoscopy.

Case 5.—J. D., a man aged 34, a hospital patient, underwent operation for a perirectal abscess on Oct. 17, 1949. During the course of the operation a culture of the pus, sent to the laboratory for bacteriologic study, was positive for Salmonella oranienburg, Escherichia coli and Streptococcus fecalis. Two weeks before his admission the patient had an episode of abdominal cramps and diarrhea after eating in a restaurant near his place of employment. The first postoperative stool on Oct. 22, 1949, five days later, was positive for S. oranienburg. Subsequent stools were negative.

Case 6.—M. Z., a white woman aged 26, was delivered of a male child on Nov. 7, 1949. Because of a recently enforced rule that all parturient mothers have stool examinations it was found that this patient was a previously undetected typhoid carrier. Salmonella typhi were found in the stool on Nov. 7, 11, 13, 15 and 21, 1949. Duodenal drainage on November 15 was positive for S. typhi. The urine was bacteriologically negative. Blood agglutination tests on November 10 were reported as follows: group D antigens were negative, d were weakly positive in 1:10 serum dilution, Vi antigens were positive in 1:16 dilution, Proteus OX 19 positive in a 1:80 dilution.

This patient was a recently arrived displaced person from Europe and was not listed as a carrier. She had typhoid fever in a concentration camp in Grodno in 1942 and typhus in 1943. There were several episodes of "gallbladder attacks" in Germany during the four years prior to her arrival here. Because of the possibility of infection in the male infant delivered at the hospital, chloramphenicol was administered. Daily stool cultures were negative for S. typhi for 12 consecutive days and again for two days almost one month later. Three blood agglutination studies for group D and d antigens were negative over a one-month period. Blood cultures performed at the same time were also negative. The infant also received typhoid immunization, but no serologic response has been noted to date, as was to be expected. The baby is well, and the mother will return to the hospital for cholecystectomy. In the meantime she is receiving chloramphenicol. Detailed studies on the mother and infant will be reported subsequently by Drs. Mond and Weil.

BACTERIOLOGIC CONSIDERATIONS

The Salmonella group comprises a complex and heterogeneous array of more than 150 strains. Their serologic differentiation is based on specific antigenic components. These consist of O, or somatic, and H, or flagellar, antigens contained in the body and flagella, respectively. These antigens are distinctive and serve as the basis for the classification scheme of Kauffmann and White, subsequently modified by other investigators. There are five major groups of Salmonella with the following representatives:

A. Paratyphi A.

B. Paratyphi B, typhi murium, Derby, Bredeney and San Diego.

C. Cholerae-suis, Oranienburg, Montevideo, Bareilly, Newport, Thompson and Tennessee.

D. Typhi, Enteritidis, Panama, Dublin and Napoli.

E. Ananatum, Senftenberg, Give, Meleagridis and Newington.

Thus it will be seen that S. montevideo (case 1), tennessee (cases 2, 3 and 4) and oranienburg (case 5) belong to group C. S. typhi (case 6) belongs to group D. Their specific antigenic patterns[7] are: S. montevideo, somatic (O) antigens VI, VII: flagellar (H) antigens g, m, s; S. tennessee, O antigens VI, VII: H antigen z_{29}; S. oranienburg, O antigens VI, VII; H antigens m, t. The importance of such studies is indicated by the first five cases. It will be seen that S. montevideo, S. tennessee and S. oranienburg are closely related by somatic antigens VI and VII. Without more detailed identification it would have been impossible to decide whether or not they were all identical and from the same source. It is evident from these studies that cases 2, 3 and 4 were identical infections and presumably hospital contact cases or from the same source. The others were sporadic, independent infections contracted elsewhere.

EPIDEMIOLOGY

Food animals appear to be the most frequent source of Salmonella infections in the human being. Infected meat, food contaminated by sewage, infected food handlers and the excreta of rodents are frequent sources of outbreaks. Human carriers are important in the dissemination of Salmonella infections. It has been estimated that approximately 10 per cent of positive stool cultures are from healthy human carriers, a large percentage being food handlers. Chronic human carriers of Salmonella strains of animal origin are rare. The carrier state is much more frequent for types of human origin. Like Shigella infections, Salmonella disease is spread by the three F's (food, fingers and flies), and the seasonal incidence corresponds to fly prevalence, being highest in summer.

CLINICAL ASPECTS

Contrary to older concepts, it is now known that most of the 150 or more recognized strains of Salmonella are pathogenic for man. All age

groups are susceptible to infection, but the very young are particularly so, with an attendant relatively high mortality. Approximately 30 per cent of all sporadic infections occur during the first decade. Inapparent or subclinical infections are largely responsible for the spread of Salmonella disease.

Our better understanding of the infectious diarrheas has paralleled their increasing incidence in the United States. This is particularly true of the Shigella and Salmonella infections. The three commonly accepted clinical types of Salmonella disease, namely, the intestinal, febrile and septicemic, are not usually as clear cut as the names imply, and it is likely that the subclinical or asymptomatic forms predominate at the present time. Yet the sigmoidoscopic picture characteristic of the disease has been noted in clinical, subclinical and asymptomatic forms alike during outbreaks.

A similar observation has been made for bacillary dysentery. In other words, pathologic changes are revealed by careful sigmoidoscopic study in Salmonella disease, particularly in the early phases, whether symptoms are present or not. This clinical observation is significant because persons with asymptomatic or subclinical forms of the disease with intestinal lesions exhibit positive cultures and are therefore potential sources for dissemination of Salmonella infection.

Preventive and control measures for enteric infections should be centered in the hands of a hospital epidemiologist. A well trained physician with a basic knowledge of simple epidemiologic procedures can fill such a rôle admirably, if given authority to act promptly in all cases, whether private or ward. Three factors have been responsible for intramural hospital outbreaks of enteric infection: (1) lack of centralized control, (2) procrastination and (3) secrecy.

At the Bronx Hospital[8] routine fecal cultures on initial employment and monthly cultures thereafter have been carried out since 1934 on all food handlers in the kitchens, dining rooms and department of dietetics and all nurses on duty in the nurseries and pediatrics service. This continuous check on possible carriers and subclinical forms of enteric disease has resulted in the detection of a considerable number of cases before outbreaks have occurred. In addition, all employes with actual diarrhea are immediately suspended from duty with pay until clinical and bacteriologic examinations prove negative.

More recently we included routine fecal cultures on all obstetric patients immediately on admission and were rewarded by the finding of an unlisted typhoid carrier (case 6). The possible serious implications to mothers and their new-born infants of failure to detect such a carrier is apparent. During the year 1949 approximately 2000 fecal cultures were made. These included repeat monthly cultures on many of our personnel. A total of five inapparent Salmonella infections was detected (0.25 per cent). As already noted, one infected person was a nurse on the pediatrics ward; three were employes in the dietary department, one of whom worked in the baby formula room, and one was a parturient mother. Not included in the figure is one patient with operation for perirectal abscess (case 5). He was not suspected of having any enteric infection, but S. oranienburg was isolated during routine culture of the pus and subsequently from the feces.

REFERENCES

1. Ingraham, H. S.: The Control of Enteric Infections in Mental Hospitals, Psychiatric Quart. **21:**592, 1947. Felsen, J.: Bacillary Dysentery, Colitis and Enteritis. Philadelphia: W. B. Saunders Company, 1945.

2. Hardy, A. V.: Frank, S.; Jarcho, S. W., and Schlosser, E. G.: Studies on the Acute Diarrheal Diseases, Pub. Health Rep. **55:**2101, 1940.

3. Schiff, F., and Saphra, I.: A New Salmonella Type, J. Infect. Dis. **68:**125, 1941.

4. Seligmann, E.: Mass Invasion of Salmonellae in a Babies' Ward, Ann. Paediat. **172:**406, 1949.

5. Watt, J., and Carlton, E.: An Outbreak of Salmonella Typhimurium Infections Among Newborn Premature Infants, Pub. Health Rep. **60:**734, 1945.

6. Rose, M.: An Outbreak of Gastroenteritis Due to Salmonella Derby, J. Hyg. **46:**151, 1948. Rubbo, S. D.: Cross-Infection in Hospital Due to Salmonella Derby, ibid. **46:**158, 1948.

7. Dr. Ivan Saphra, New York Salmonella Center, confirmed our identification of these strains.

8. Felsen, J., and Wolarsky, W.: The Hospital Epidemiologist, Hosps. **14:**41, 1940.

Heyden PENICILLIN and STREPTOMYCIN

CONSIDER THE SOURCE!

Like an uninterrupted supply of motive power, Heyden Penicillin and Streptomycin serve the medical profession with quality and uniformity that are constant. Through advanced research and manufacturing methods, users of these superior antibiotics are protected against fluctuations in production, price and delivery. For these important reasons, outstanding consumers and packagers alike consider the source—and invariably the answer is Heyden Penicillin and Streptomycin!

PENICILLIN PRODUCTS

Vials: Crystalline Penicillin G Sodium or Potassium; Crystalline Procaine Penicillin G in Sesame Oil with 2% Aluminum Monostearate w/v (cartridges, single- and multiple-dose vials) (also available in fortified form); Crystalline Procaine Penicillin G for aqueous injection (single- and multiple-dose vials of "PPA") (also available in fortified form).

Tablets: Buffered Crystalline Penicillin G Potassium (50,000, 100,000 and 250,000 units, sealed in foil, for oral use).

Crystalline Penicillin G Potassium Soluble (50,000 and 100,000 units, sealed in foil, for oral use).

Troches: Crystalline Penicillin G Potassium, (5,000 and 10,000 units, sealed in foil, pleasingly flavored, slow to dissolve).

STREPTOMYCIN PRODUCTS

Crystalline Dihydrostreptomycin Sulfate (1-gm. and 5-gm. vials).

Dihydrostreptomycin Sulfate (1-gm. and 5-gm. vials).

Streptomycin Sulfate (1-gm. and 5-gm. vials).

OF INTEREST TO MANUFACTURER-DISTRIBUTORS

Heyden's unusual and exclusive service to packagers of Penicillin and Streptomycin products protects YOUR sales and profits under YOUR OWN NAME. Specially designed prescription-type cartons and unit containers are ready for your specific labelling. Technical literature, brochures and instruction inserts are supplied without cost. Write today for detailed particulars.

CONSIDER THE SOURCE! . . . and you'll specify HEYDEN

HEYDEN CHEMICAL CORPORATION

Professional Products Division

225 WEST 34TH STREET, NEW YORK 1, N. Y.

FINE HEYDEN CHEMICALS

Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

Historical Aspects of Synthetic Drugs

SINCE man's attainment of his reasoning powers, he has tried to modify his environment to make existence more certain and life more comfortable. Most of the early discoveries which benefited mankind were purely accidental. Our present-day discoveries are still mainly trial and error, but are more productive in that the research activities in pharmacology have multiplied to the point where, if "606" represents the research in Ehrlich's day, then the rest of Avagadro's Number, namely "ten to the 23d power," represents the increment since Ehrlich's day. Avagadro would be pleased with this increase in frenzied activity, but he would probably be chagrined to learn that we still require 40,000,000 molecules of a potent arsenical to kill one trypanosome in a heavily infected rat, and one hundred years after the discovery of ether anesthesia we still do not know exactly how anesthesia is produced.

TRIED TO UNCOVER NATURAL LAWS

Man has never been satisfied with the trial and error approach, but has attempted to uncover the fundamentals or natural laws which may underlie his vast sea of empirical knowledge regarding potent drugs. He has thus attempted to sort out science from technology by frequent, critical appraisal of empirical knowledge. Many such attempts have been made in the past.

One of the first such attempts at structure-activity relationships (SAR*) correlation was in 1702 when microscopic examination of poisons which had been extracted from plants (or even from the bodies of poisoned victims) showed them to consist of small sharp needles. An investigator of that day, Richard Mead, concluded that poisons acted by mechanically tearing the tissues with which they came in contact. Prior to this, J. J. Wepfer in 1679 had studied in a systematic manner the inorganic iodides, bromides and heavy metals. Brown and Frazer have usually been given credit for the first structure-activity studies, and this honor is probably bestowed properly since most of our drugs today are of an organic nature and it is in this class of drugs where SAR is most intriguing and, at the same time, most difficult to unravel. In 1868 Brown and Frazer showed that block at the myoneural junction (curare-like action) was associated with quaternary nitrogen atoms and the only exception to date of an active curare-drug which is not a quaternary is Beta-erythroidine which as a tertiary amine has strong curare-like action which may in part be due to a depressant action on the spinal cord. (The quaternary compound of Beta-erythroidine is less active as a curare-drug.)

Brown and Frazer studied the methyl iodide or sulfate derivatives of various alkaloids. Of these, strychnine, brucine, thebaine, codeine, morphine and N-methyl coniine were drugs which act on the central nervous system. They were able to show that all of these (1) became less toxic, (2) lost their central activity, and (3) became agents which blocked the neuro-myal junction, *i.e.* curariform. In 1872 they further proved that other onium salts, such as trimethyl sulf*onium* chloride, were also blocking agents at the neuromyal junction. Brown and Frazer dosed their animals on a body weight basis and kept accurate protocols.

As noted in Meyer and Gottlieb V. Mehring and Schneegans in 1892 were impressed with the depressant potency of an increased number of ethyl groupings in the aliphatic hypnotics, for example:

Hypnotic Dose—Rabbits

4.0 grams Trimethyl Carbinol	2.0 grams Amylene Hydrate	1.0 gram Triethyl Carbinol
CH_3	CH_3	Et
CH_3C-OH	CH_3C-OH	$Et-C-OH$
CH_3	Et	Et

Another example of this increasing effect of the ethyl group on the central nervous system is given by Spiegel for the pinacols.

Hypnotic Dose
10.0 grams
2.0 grams
1.5 grams

Tetra Methyl pinacol

Hypnotic Dose 10.0 grams

$(H_3C)_2C-C-(CH_3)_2$
OH OH

*SAR is the abbreviation coined by Dr. S. Loewe to facilitate conversation in this field. The older phraseology is: "The relationship of chemical structure to pharmacological action." In the opinion of the reviewer, the term "Biochemomorphology" was as good a disguise for the subject as SAR, but needlessly complex and, hence, over a period of years has not gained common usage.

Amebiasis

OCCURS THROUGHOUT THE U. S. A.

Intestinal • Extra-Intestinal (Hepatic)

"The geographical distribution of amebiasis is world-wide."[1] "Although amebiasis is often considered a tropical disease, it is prevalent even in certain arctic regions."[2]

INCIDENCE OF AMEBIASIS IN THE UNITED STATES

STATE	NO. EXAMINED	NO. POSITIVE	% POSITIVE
New York[3]	350	34	9.7
Pennsylvania[4]	1060	43	4.1
Minnesota[5]	5000	535	10.7
Illinois[6]	4478	601	13.4
Oklahoma[7]	924	92	10.0
Washington[8]	1526	164	10.7
California[9]	1341	92	6.9
Louisiana[10]	4270	355	8.3
Tennessee[11]	20,237	2,305	11.4
New Mexico[12]	1284	190	14.8
Total	**40,470**	**4,411**	**10.9**

Intestinal. Comparative in vitro studies have shown that Milibis, the new intestinal amebacide, is one of the most powerful of the drugs commonly used against Endamoeba histolytica. In clinical tests Milibis has given excellent results in thousands of cases. In 82.6 per cent of those that could be followed parasitologically for prolonged periods, negative stools were obtained consistently after one to four courses of Milibis treatment.[13] There were virtually no side effects.

Dose for adults: 0.5 Gm. three times daily for seven days. If stools remain positive, course should be repeated. Supplied in tablets of 0.25 Gm., bottles of 50.

Extra-Intestinal. Aralen, an established antimalarial of relatively low toxicity, has been found remarkably effective in the treatment of extra-intestinal amebiasis (amebic hepatitis).[14-21] This discovery is particularly important because of the likelihood of extra-intestinal involvement in chronic amebiasis.

Dose for adults: 4 tablets daily in divided doses for two days, followed by 2 tablets daily for two to three weeks. Administer before, after or together with Milibis treatment. Supplied in tablets of 0.25 Gm., bottles of 100 and 1000.

MILIBIS®
Bismuth Glycolylarsanilate

ARALEN®
DIPHOSPHATE
Chloroquine Diphosphate

Write for detailed information.

Winthrop-Stearns INC.
NEW YORK, N. Y. WINDSOR, ONT.

1. Craig, C. F.; 2. Almy, T. P.; 3. Towse, R. C., et al.; 4. Wenrich, D. H., et al.; 5. Sanford, M. F.; 6. Spector, B. K.; 7. McMullen, D. B., and Gray, J. K.; 8. Cresswell, S. M., and Wallace, C. E.; 9. Wight, T.; 10. Faust, E. C., and Headlee, W. H.; 11. Meleney, H. E., et al; 12. Spector, B. K., and Hardy, A. V.; 13. Berberian, D. A.; 14. Conan, N. J.; 15. Shookhoff, H. B.; 16. Sodeman, W. A.; 17. Murgatroyd, F., and Kent, R. P.; 18. Basnuevo, J., and Estarli, E. G.; 19. D'Antoni, J. S.; 20. Manson-Bahr, P.; 21. Emmett, J. Full bibliography on request.

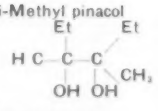
Milibis, trademark - Aralen, trademark reg. U. S. & Canada

Table I—Examples of Competitive Inhibition

METABOLITE	ANTAGONIST	TEST ORGANISM	WORKER	DATE
PABA	Sulfas, PAA Phenone	Hem. Strep.	Wood	1940
Methionine	Sulfas	E. coli ?	Harris and Kohn	1941
Guanine, Xanthine	Sulfas	E. coli	?	
Methionine	Ethionine	E. coli	Harris and Kohn	1941
Methionine	Methoxinine	E. coli	Roblin et al.	1945
Tryptophane	Indoleacrylic acid	E. Typhosa	Fildes	1941-5
Tryptophane	Indole	Bacteria	Fildes and Rydon	1947
Phenylalanine	B-hydroxy phenyl alanine	E. coli	Beerstecher and Shive	1947
Desthiobiotin	Imidazolidone caproic acid	Bacteria	Rogers and Shive	1947
Glutamic acid	Methionine sulfoxide	Staph. Aureus	Shive	
Nicotinic acid	Pyridine-3-sulfonic acid	Bacteria	McIlwain	1940
	3-acetyl pyridine	Bacteria	Snell	1941
Pantothenic acid	Pantoyl-Taurine	Other bacteria too	Shive and Snell	1945
Pantothenic acid	Phenylpantothenone	Lactobacillus casei	Woolley	1945
Riboflavin	Phenazine analogue	Various	McIlwain	1941
Amino acid	Sulfonic acid analogue	E. coli	Shive	
Aspartic acid	Hydroxy aspartic acid	Fungi	Tracy and Elderfield	1940
Thiamine	Pyrithiamine	Mice	Woolley and White	1943
Thiamine	Pyrithiamine	Guinea pigs	Woolley	1944
Ascorbic acid	Glucoascorbic acid			

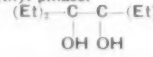
di-Ethyl, di-Methyl pinacol

2.0 grams



Tetra Ethyl pinacol

1.5 grams



The knowledge of these observations (which holds only for selected groups of the aliphatic hypnotics) and the application of this rule to the cyclic barbiturates led Emil Fischer and Von Mehring in 1903 to select di-ethyl barbituric acid as their "best" hypnotic although even their pharmacological studies indicated that the dipropyl was more potent.

They routinely gave a 1 gram oral dose of each drug to a dog and observed the animal for a six-hour period. If this dose killed the dog (which occurred with the dipropyl) then the drug was too toxic! Several years later they restudied the dipropyl derivative and suggested that their initial compound was lethal because of impurities whereas actually in their initial studies the threshold dose or margin of safety had not been determined.

The other analogues of their 1903 paper are also of interest in that these early workers made, but inadequately studied, the following:

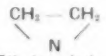
diethyl-thio barbituric acid

diethyl N-methyl barbituric acid

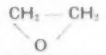
The first systematic study of totally synthesized chemical compounds with a specific goal in mind was that of Einhorn who introduced procaine as a substitute for cocaine in 1905. This trial and error research, which was based on the work of Filehne in 1887 with benzoyl esters, continued from 1892 to beyond 1905, resulted in such an excellent local anesthetic that it is still the most widely used agent of this class today. It is fortunate that Einhorn went ahead without waiting for a theory to guide him, since even today the exact mode of action of local anesthetics is still somewhat of a mystery. Einhorn's study, while monumental, is not a landmark in the pharmacology of synthetic drugs since the study was done in an industrial laboratory and the long list of compounds which did not produce local anesthesia was never published.

The next important drug of synthetic origin and the first application of SAR to chemotherapy were the work of Paul Ehrlich and his associates which led to the discovery of Salvarsan, or "606." This discovery lasted for 30 years until sufficient experience was gained in animals with the half molecule oxophenarsine to use this drug for spirochetal diseases. Since 1944 the phenylarsenoxides have been relegated to second place with the demonstration by Mahoney of the treponemicidal action of penicillin. However, the value of trial and error research was again borne out by the fact that the arsenicals were the drugs of choice for 15 years even before Voegtlin elucidated a rational theory for their action.

However, Ehrlich not only discovered a practical drug, but also introduced many terms which are with us today, such as "chemotherapy" and "chemoreceptor" for the site of action of the chemical on the parasite. Ehrlich further identified the receptors on cells as "Iodo-receptor," "Amine-receptor," "Acetico-receptor," and for "Salvarsan" an "orthoamidophenol-receptor" which conditions the fixation of arsenic in the parasite. Ehrlich also suggested the simultaneous use of more than one chemotherapeutic agent to prevent the parasite from developing drug resistance, "multiple agents (which like soldiers) march apart, but fight combined." According to Siegel, Ehrlich studied ethylene imine and found it to be one of the rare substances which formed a chemical bond to the receptors of protoplasm because this substance had a long duration of action and effected a lasting and peculiar change in tissue. Here was the known, but unutilized, basis for the "Dibenamine" type of adrenergic blockade. Ehrlich also found the same to be true of dimethylene oxide which is now used as a hospital disinfectant presumably because it combines with the protein of bacteria.



Ethylene imine



Dimethylene oxide

Going back to pharmacodynamics, we believe the classical studies on pressor amines by Barger and Dale in 1910 should receive prominent mention. They elucidated the structural requirements of the ethyl phenyl amines for both maximal pressor effect and duration of action. They further studied the excitatory and inhibitory effects on specified tissues and noted that the magnitude of changes in pressor activity were not followed by similar changes in inhibitory action. Of the published reports of early work theirs was the most exhaustive and complete. Neither Einhorn nor Ehrlich published material on the entire series of chemical compounds which they studied, or even on a major portion. In this regard, Barger and Dale set a new standard in their publication of all of their derivatives which should be more closely adhered

Urokon Sodium Brand
of Sodium Acetrizoate

1 Low Toxicity
2 Few Side Reactions
3 High Quality Pyelograms
4 Quick Pictures
5 Economical
6 Immediately Available

Urokon is immediately available in convenient packages of one, five and twenty ampuls of 25 cc each.

—a new Contrast medium for Urography by

Mallinckrodt®

MALLINCKRODT CHEMICAL WORKS
Mallinckrodt St., ST. LOUIS 7, MO.
72 Gold Street, NEW YORK 8, N. Y.
CHICAGO • CINCINNATI • CLEVELAND • LOS ANGELES •
PHILADELPHIA SAN FRANCISCO • MONTREAL • TORONTO

May we send you reprints of published clinical reports and other data concerning the above points? Mail the coupon.

Mallinckrodt Chemical Works
Second & Mallinckrodt Sts., St. Louis 7, Mo.
or
72 Gold Street, New York 8, N. Y.

Gentlemen: Please send me full information and clinical reports on Urokon Sodium.

NAME_____ M.D.

STREET_____

CITY_____ STATE_____

to in our current publications. Barger and Dale also set a new high standard for pharmacological testing which was woefully deficient in previous studies.

Since the initiation of modern pharmacological studies by Barger and Dale, numerous other reviews have been written on SAR. None, however, attracted the widespread attention accorded to Wood's elucidation in 1940 of the possible mode of action of sulfanilamide. In making this correlation, Wood also discovered a new vitamin or essential food element which is necessary for bacterial growth. The essentials of the theory are amazingly simple, namely, that sulfanilamide is sufficiently similar to para-aminobenzoic acid (PABA) to inhibit in a reversible fashion the enzyme system which ordinarily would use the PABA. This is now called "competitive inhibition" and we know that the inhibition follows the laws of mass action so that a definite ratio of metabolite to inhibitor is maintained for an altered concentration of either. One molecule of PABA successfully competes with 10,000 molecules of sulfanilamide.

The elaboration of the concepts of competitive inhibition has resulted in the synthesis of numerous analogues of other essential metabolites (table 1). Thus, the sulfonic acid analogues of many of the amino acids and vitamins have been synthesized. Various ring structures of the vitamins have been altered as in pyrithiamine, acetylpyridine, and desthiobiotin. Several inhibitors which were known prior to Wood's publication have now been classified as competitive inhibitors. Among these are the inhibition of succinic acid by malonic acid (Haldane 1930), and vitamin K by dicoumarol (Link 1939). Other newly discovered drugs can now be classified in a similar manner, *i.e.* the insecticide "Gammexane" is antagonistic to meso-inositol and "aminopterin" is antagonistic to pteroyl glutamic acid (folic acid).

Considering the hundreds of compounds which have been synthesized with the concept of competitive inhibition in view, we find the number of successful compounds for use in therapeutics are few indeed. However, our basic knowledge of biochemistry and pharmacology has been greatly aided by this concept which with greater development of studies in SAR may remove some of the guesswork from the synthesis of new drugs.—C. C. PFEIFFER, Ph.D., M.D.

When it is SUPPLIES WECK supplies only the FINEST

Just as "a man is known by the company he keeps," so any supplier in any field, is known by the company he keeps as to other suppliers.

A leader in its field of manufacturing surgical instruments, Weck, naturally supplies only the finest surgical instruments. Likewise when it is hospital supplies which are made by other manufacturers, Weck supplies only the finest, such as those shown by name or trade-mark above.

In each sub-division Weck has carefully analyzed, studied, compared, and selected the supplier, or suppliers, in that sub-division which is "tops" when it comes to quality, service and dependability.

Then to top that off WECK *guarantees* UNCONDITIONALLY any and all supplies sold by the 60-year old House of Weck.

Electric diagnostic, glassware, surgical needles, rubber goods and supplies, furniture, sutures and suturing material, white enamelware, or stainless steelware, when you get them from Weck you get only the finest, always.

Whatever your hospital instrument or surgical supply need WRITE WECK FIRST, or see the Weck salesman on his next call.

For hospitals too are known by the company they keep as to equipment and supplies, of course.

REMEMBER WECK INSTRUMENTS ARE MADE CORRECT—SOLD DIRECT—to HOSPITALS!

EDWARD WECK & CO., INC.

Manufacturers of Surgical Instruments

SURGICAL INSTRUMENT REPAIRING • HOSPITAL SUPPLIES

135 Johnson Street · Brooklyn 1, N.Y.

WECK
STAINLESS STEEL & CRODON
FOUNDED 1890

Conducted by Mary P. Huddleson

A dietitian defines the

Objectives of a Public Relations Program

E. ALLIENE MOSSO
Supervising Dietitian
St. Luke's Hospital
New York City

BUSINESS has determined that the object of public relations is to develop the good will of your public. This is as true for the professions as it is for business.

Dietetics is a profession closely concerned with the welfare and health of the public and members of this profession have felt an acute need for the furtherance of public relations since the development of good will is essential. Every dietitian's primary job is to know her patrons and to furnish them good nutrition suited to their needs. A successful dietitian knows her public.

HAS THREE GOALS

It follows then that the principal objective of a successful public relations program, so far as dietitians are concerned, should be designed:

1. To make dietitians cognizant of their professional responsibilities in the performance of their duties and thus personally to exemplify the standards of their association.

2. To obtain the aid of local dietetic associations in establishing well defined standards of practice in order to eliminate unethical practices within the profession at the community level; for example, well defined qualifications for dietitians and others discourage unqualified persons from entering the profession.

3. To enlist sponsorship of newspapers and magazines in bringing to the attention of the public, through educational articles, the professional standards to which qualified members of dietetic organizations have pledged themselves.

These objectives can do much to elevate the standing of dietitians in the hospital, the local community, the state, the nation and elsewhere. To illustrate, a dietitian in a hospital must take her place on an equal footing with other heads of departments by demonstrating her value as an essential factor in management. She has been trained in the scientific feeding of people, she knows how to purchase food and equipment, and she understands the principles of management and training of employes so that they will produce well prepared, attractively served food.

The dietitian's influence not only affects the preparation of food, it is also felt in the community through the teaching of the principles and precepts of good nutrition to patients in hospital wards and clinics and in other health organizations. Inasmuch as health organizations are of state, national and sometimes worldwide significance, her influence is far-reaching.

By taking her rightful place in management, the dietitian will elevate the standards of her profession. Administrators will see the value of her training and will remunerate accordingly the person who is capable of managing. Better working conditions and adequate remuneration for the members of the profession will aid in recruiting more competent people to replace the many who are leaving hospital work for other positions offering greater inducements at present.

To obtain the proper perspective or starting point for a public relations program, it might be well to survey the situation and determine the following:

1. The reason for and the extent of the shortage of dietitians.

2. The number of positions filled at present by unqualified dietitians.

3. The reasons dietitians are leaving hospital work.

4. The types of positions dietitians are taking on leaving hospital work.

5. What reports dietitians are rendering hospital management.

6. How dietitians are publicizing themselves in hospitals.

Dietitians, like others, need the good will of their public and associates. Working with us daily to improve conditions is the personnel of the department of public health, the American Hospital Association, the United States Department of Agriculture, social service workers, the Nutrition Foundation Research Program, members of nursing associations, and food producers. In the community with us are the civic organizations, life insurance companies, chambers of commerce, advertising councils, restaurant associations, physicians, the friends of our patients, and the schools, colleges, churches, book publishers and magazine editors who are interested in the health and well-being of the community. How can the members of the local dietetic associations take advantage of the opportunities our associates offer us?

HOW THE A.D.A. CAN HELP

The American Dietetic Association's public relations committee serves as an advisory committee on all types of publicity, news releases to local papers, type of programs to be given local organizations, legislative activities, statements of dietitians for public releases, newspaper and magazine articles, radio addresses and so forth.

Executive committees of state dietetic associations could perhaps act as planning bodies and formulate objectives of a public relations program. The technical phase of the work could be carried on by the committees already set up; that is, professional education committees could work along the lines of recruitment and the chairman of the committee could act as liaison officer with the other professional education committees in local groups, so that the work could be projected throughout the state.

Sexton
Quality Foods

Distinctive all the way

Into every container of Sherman exquisite coffee goes something that is not grown in the bean. It is the essence of all that we have learned in the past sixty-six years of the art of blending fine coffees . . . of roasting and packing them exclusively for those who cater to the public. That means something to you! It means uniformity, full value and certain guest satisfaction.

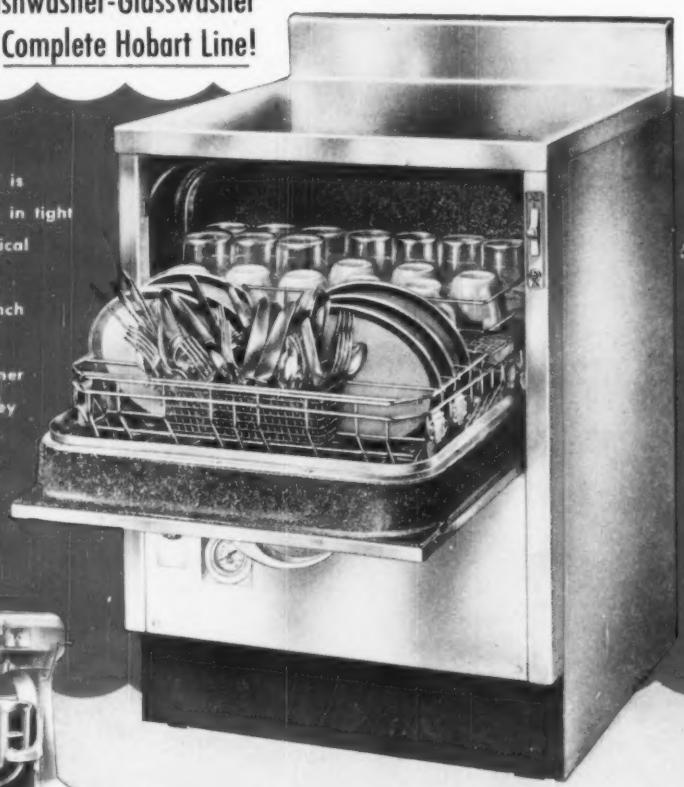
JOHN SEXTON & CO., 1950

Good Food for Pleased Guests

It's the Big Wash-Word!

Hobart's Model UM-P Dishwasher-Glasswasher
Big Little Member of the Complete Hobart Line!

Hobart's versatile Model UM-P is designed for efficient operation in tight quarters. It's compact, economical and *fully-automatic*—perfect for soda fountains, snack bars, lunch or beverage stands and small restaurants. It speeds up customer service . . . saves time and money . . . reduces breakage. It's the kind of labor-saver you'll want to include in your plans for greater operating efficiency.



MIXER
Model A-200

Angle-Feed SLICER
Model 1512

TENDERIZER
Model 200

And while you're planning—remember these Hobart profit-builders: *Steakmaker* Tenderizers for making tempting, *tenderknit* steaks from a variety of cuts; slicers for uniform slicing of boneless meats (hot or cold), bread, cheese, vegetables and fruits; mixers and attachments for every-day food preparation. All are attractive, compactly built, clean in design and clean in performance.

Call your local representation of Hobart—they're in the best position to give full details. Let them help anticipate your needs.

*Steakmaker** tenderizers are manufactured by Hobart-Federal Engineering Corporation, a Hobart subsidiary.

* Trade ® Mark

Machines illustrated represent only a fraction of the complete Hobart line. Ask for Hobart representative or write Dept. 2, Troy.

TRADE MARK OF QUALITY

Hobart *Food Machines*

THE HOBART MANUFACTURING CO., TROY, OHIO • Factories in Troy, Dayton, Greenville, Minneapolis, U.S.A. • *The World's Largest Manufacturer of Food and Kitchen Machines*

CANADA • BRAZIL • ENGLAND • AUSTRALIA • FRANCE

When Turkey Appears on the Menu

it makes good meals at reasonable cost

WHEN the hospital patient is served a meal he is looking down on 20 to 25 per cent of the total expense of operating a modern hospital. And of major concern to the hospital expense experts is the cost of the meat serving on that tray.

The annual consumption of meat for the approximately one million general hospital beds in the country is estimated at more than 210,000,000 pounds a year. It is natural that economies are continually being sought for such a large item on the hospital budget.

Meat serving in hospitals rounds itself into such problems as "What type of meat do most patients prefer?" "What type is best from a nutritional point of view?" "How many uses can one type of meat be put to?" "How much meat should be used in one serving?" "How many different types of meat should be served over a given period?" "What is the most economical type of meat to serve?" . . . and numerous other questions.

To answer all these involves experience and study. But to give an insight into the last question, "What is the most economical type of meat to serve?" the National Turkey Federation, in cooperation with The MODERN HOSPITAL, sponsored a study in some of the leading hospitals throughout the country. It should be explained that the hospitals were given a free hand in the methods used to obtain their findings. They were merely asked: "In a carefully controlled test, will you ascertain the costs for one serving of various types of meats?"

St. Luke's Hospital in Chicago conducted its meat cost test on three consecutive days. The variance in the results each day was slight. The findings were reported on how the cost of one serving of a type of meat compared with the cost of one serving of turkey. The test did not take into consideration the turkey scraps that could be used for salad, à la king, and so on, or the carcass to be used for soup. Such usages increase still more the economical value of turkey. Results at St. Luke's were:

Cost of one serving of roast chicken: 119.5 per cent cost of one serving of roast turkey

Cost of 4 ounce serving of pot roast beef: 127.1 per cent cost of one serving of roast turkey

Cost of 4 ounce serving of roast leg of veal*: 90.58 per cent cost of one serving of roast turkey

Cost of 4 ounce serving of roast pork loin: 112.7 per cent cost of one serving of roast turkey

* It must be noted here that the weight of the bone was included in the 4 ounce serving of roast veal. As the bone accounts for approximately one-third of the weight of the serving, the actual edible portion is less than 3 ounces. If the edible portion of the veal were 4 ounces, its cost would exceed that of turkey.

Comparison of Cost of Meat Servings, Orange Memorial Hospital, Orlando, Fla.

Kind of Meat	Pounds Purchased	Price* per Pound	Total Cost	Served as	No. of Meals Served	Ounces per Serving	Servings per Pound	Cost per Serving as Purchased	Cost per Pound Edible Portion	Hashmeat	Stock	Fat Rend.	Waste and Bone
Turkey	267	$0.56	$149.52	Roast	392	4 oz.	4	.381	$1.524	18 & ¾	18 qts.	4½#	23# 11#
Prime Ribs Beef	276	0.53	146.28	Roast	317	4 oz.	4	.432	1.728	59# 27#	8½ qts. nat. juice	11#	23#
Stewing Hens	154	0.57	87.78	Chicken a la King	350	2¼ oz. (for 4 oz.	7	.222 .3936)	1.554	—	23 qts. broth	6#	35# 15# skin
Roast Veal	239	0.48	114.72	Roast	335	3⅓ oz. (for 4 oz.	5	.342 .4104)	1.71	56#	12 qts. broth from bones	—	72# bone and ! waste
Roast Pork Loin	153	0.52	79.56	Roast	266	6 oz. (Incl. loin bone)	2⅔	.299	.797	—	—	12#	8# trim 5# bone

* At time original study was made. Prices as of September 1950 were: Turkey, 0.59; Prime Ribs of Beef, 0.59; Stewing Hens, 0.35; Roast Veal, 0.53; Roast Pork Loin 0.50.

Cost of one serving of stewed chicken (sliced): 101.5 per cent cost of one serving of boiled turkey (sliced)

Cost of one serving of stewed chicken (creamed): 173.0 per cent cost of one serving of boiled turkey (creamed)

On page 105 is the chart on a comparison of meat servings from the Orange Memorial Hospital, Orlando, Fla. It must be explained here that 4 ounces of turkey and prime ribs of beef were served while 2¼ ounces of stewing chicken, 3⅓ ounces of roast veal, and 6 ounces of roast pork loin were used. To serve 4 ounces of stewing chicken, projecting the costs recorded in this study, would have cost $0.393, and to serve 4 ounces of roast veal would cost $0.410.

Note that the serving of roast pork loin includes the loin bone. As the bone, in this case, amounts to about 40 per cent of the total weight, the actual edible portion of meat is a little more than 3 ounces and the cost of serving 4 ounces, to compare with the others, would bring the cost of the serving to approximately $0.400.

Thus, ounce for ounce of edible meat, turkey costs less to serve, followed by stewing hens, roast pork loin, roast veal and prime ribs of beef in that order.

The Peter Bent Brigham Hospital in Boston conducted meat cost tests over a two-month period. As in the foregoing test, the weight of the meat is not the same in each case. To comprehend the true comparison of cost, it is necessary to note the weight of the serving as well as the cost per person.

This analysis again shows that turkey, served in casseroles, salad and à la king, and as roast turkey leads the list with a large serving for a relatively low cost.

Following is the average cost per serving over the two-month period (at the time the study was made):

Meat	Aver. Cost per Serving	Aver. Weight per Serving
Turkey served in casseroles as salad as a la king	$0.235	.67
Turkey served as Roast Turkey	0.310	.86
Fryers served as Fried Chicken	0.379	1.00
Veal leg served as Roast Veal	0.166	.43
Fowl served as Sliced Chicken	0.344	.80
Fowl served in casseroles as salad as a la king	0.275	.66
Sirloin butts served as Roast Beef	0.299	.61
Pork loin served as Roast Pork	0.392	.80

Results of a test conducted at Albany Hospital in Albany, N.Y., are shown in the accompanying table. Note that all weights, with the exception of fried chicken and roast pork, are the same.

In support of the economy of using turkey in hospitals, Thomas Hale Jr., director of Albany Hospital, says that the dietitians of that hospital are certain that broad-breasted heavy tom turkey is by far the most economical meat product used. This is true not only because of the economy with which it can be cut into servings, but also because there are so many uses for all bits of left-overs, down to the carcass as a basis for soup stock.

Results of these tests vary some with the different hospitals and their locations in the country and with their methods of making the studies. In every study, however, these findings show that turkey is the most economical meat to use.

According to studies made by The MODERN HOSPITAL, the typical 100 bed hospital, during a typical 12 month period, purchased a total of 26,346 pounds of meat. Of this, 3268 pounds, or 12.4 per cent of the total, was poultry. Of the poultry, 431 pounds, or 13 per cent of the poultry total, was turkey. There are approximately one million hospital beds in the country. Projecting the typical hospital figure for a 100 bed hospital to one million beds, with proper weighting for average occupancy, shows an annual meat consumption of 210,120,000 pounds. Of this, 22,870,000 pounds is poultry and 3450 pounds is turkey.

The results of tests similar to those recorded here, showing turkey to be

Results of Test Conducted at Albany Hospital, Albany, N.Y.

Kind of Meat	Total Wt.	Wt. of Meat	Wt. of Waste	Wt. of Bones	Cost per Lb.	Cooked Wt. of Meat (Usable)	Wt. per Serving	No. of Servings	Cost per Serving Cooked
Roast Turkey**	896		250		$0.40 (*) 0.42 (†)		3 oz.	736	$0.150
Stewing Chicken	5 lb.		1 lb.		0.33 (*) 0.34 (†)	1 lb. 12 oz.	3 oz.		0.177
Roast Beef (Rib)	19 lb.	4 lb.		6 lb.	0.45 (*) 0.63 (†)	4 lb. 9 oz.	3 oz.		0.186
Roast Veal (Leg)	25 lb.	16 lb.		9 lb.	0.49 (*) 0.65 (†)	11 lb.	3 oz.		0.208
Roast Lamb (Leg)	11 lb.		5¼ lb.		0.45 (*) 0.58 (†)	4 lb. 4 oz.	3 oz.		0.216
Fryer Chicken	2¾ lb.				0.36 (*) 0.36 (†)			4 per bird	0.247
Roast Pork (Loin)	8 lb.		1 lb.		0.58 (*) 0.53 (†)	4 lb. 6 oz.	4 oz. c bone		0.265

* Cost per pound when original tests were made.
† Cost per pound in September 1950.
** In addition to the serving of roast turkey, there was enough meat left over for 1440 assorted servings. This, of course, actually lowers the price of the roast turkey further although even without the "left-overs" turkey is two cents per serving below the cost of any other meat. The remaining turkey was used as follows:

80 pounds in club sandwiches.....440 servings
45 pounds in turkey salad.....200 servings
15 pounds small pieces and skin, turkey scrapple.....200 servings
15 pounds turkey wings creole.....60 servings

The average cost of a serving of turkey in these dishes was $0.069
In addition, carcasses were used in making soup.


Hospitals especially require
More Coffee Flavor
Yes—MORE coffee flavor, because the heaviest users of coffee in every hospital are keen, critical judges of good coffee. They are your staff members. Please these discriminating people and there is never a doubt about pleasing your patients.
Flavor . . . deeper, richer, more pronounced coffee flavor . . . coupled with full body and uniformity of brew is Continental's outstanding quality characteristic. Flavor . . . More Coffee Flavor . . . has established Continental as America's leading coffee for restaurant and institutional service.
Try Continental yourself! Ask your Continental man for a free trial package—or write direct.
YOU'RE SURE TO PLEASE YOUR PATIENTS WHEN YOU PLEASE YOUR STAFF
ONE POUND NET
CONTINENTAL
WB BLEND
COFFEE
Continental Coffee
AMERICA'S LEADING COFFEE for RESTAURANTS, HOTELS AND INSTITUTIONS
CONTINENTAL COFFEE COMPANY—CHICAGO 90, ILL.
BROOKLYN 1, N. Y. • TOLEDO 1, OHIO
Importers, Roasters Member: New York Coffee and Sugar Exchange, Inc.
MAKERS OF CONTINENTAL'S "76" MENU PRODUCTS

the most economical meat to serve, are known to many of the hospitals throughout the country. Yet it is apparent from the relatively small usage that many other hospitals are not yet aware of the greater economy in the use of turkey.

In recent years the use of turkey has made a notable gain not only during holiday times, but as a year-round food. Some of this popularity has resulted from the development of a modern "meat-type" turkey. This full breasted, tender, plump bird now yields a splendid poundage of meat, mostly white, in a relatively short growing season of 28 to 32 weeks.

USED ALL YEAR-ROUND

With the development of this new "meat-type" bird came new interest in using turkey on a year-round commercial basis. Now many hotel owners, restaurant operators, food buyers, and hospital officials find turkey has numerous advantages over other cuts of meat. A recent survey indicates that turkey purchases for commercial use more than doubled between 1940-45. In the past, the poultry entrées on the menu were mainly chicken. Now a large number of these have been changed to turkey.

Once thought to be a delicacy that could be afforded only on holidays, turkey now appears in an entirely different light. Many institutions, including hospitals, have found that they can obtain from 60 to 70 generous servings from a 30 pound turkey. Thus, they have discovered that a serving of turkey actually costs less than a serving of other first quality meat.

Further reason for using turkey in hospitals is supplied by Lawrence Nelson, assistant administrator, Wesley Memorial Hospital, Chicago.

This 600 bed hospital, in which more than 90,000 meals a month are prepared, serves turkey as a regular menu item and, in addition, has it on request at all times. It is served as roast turkey, à la king, and in salads and sandwiches. It replaces chicken in stews and pot pies. Mr. Nelson reports that in à la king dishes 25 per cent more is derived from turkey than from chicken.

This hospital uses 4 ounces of turkey in a serving of turkey and dressing. If chicken were used, it would require a full half ounce more to make a serving of satisfactory appearance. This is true because turkey is better adapted to slicing in longer pieces and therefore, when served with dressing, appears more substantial.

A 4 ounce serving of turkey gives the appearance in volume of a 5¼ ounce serving of beef. Thus, it is seen that turkey is particularly suitable because it enables the hospital to serve a satisfying meal with a smaller portion of meat. The longer slice of meat which can be cut from turkey makes a smaller portion look larger.

To establish turkey's case on the hospital menu, Mr. Nelson points out:

"There are many factors to be considered in choosing turkeys over chickens. We have found that there is a considerable saving in labor and time in food preparation. The cuts derived from turkeys are much more adaptable for sandwich use, the meat is firmer and easily handled; hence, a much better appearing sandwich results.

"We have found that the most economical weight in chickens is from 5 to 6 pounds. This gives us about six servings to one chicken, which means that we must use seven chickens weighing 35 pounds to equal the servings from a turkey weighing 25 pounds. We have also used 4½ pound chickens and it takes eight of this size to equal the servings from a 25 pound turkey. There is more fat in proportion to meat with chicken, which cuts down the usable meat poundage; however, this fat is rendered and used, as it is highly desirable for cooking.

"Under present conditions prices are not stable enough to arrive at an accurate cost basis on price alone, but we have found that prices figure out very closely on a poundage basis and leave many advantages favoring the use of turkeys."

Elizabeth Tufts, head dietitian of the hospital, explains that turkey can be added to any diet that allows chicken and can be used for general, soft, low residue and other diets. In fact, it can be served on any diet except those particularly prescribed for a special condition. It is high in nutritive value.

According to this hospital, patients show the following order of preference for meats: (1) roast beef, (2) breaded lamb chops, (3) turkey (90 per cent or more of the patients like turkey), (4) pork, and (5) fried chicken.

Turkey and beef are not competitive now because of the high price of the latter. High operating costs often prohibit hospitals from serving the choicest cuts of red meats, but a Grade A turkey is generally within the price minimum.

Turkey is a definite time-saver because it holds better than chicken or any other meat. Roast turkey can be prepared during slack hours in the kitchen, and then heated just before serving. Practically no shrinkage results from this reheating.

For greatest economies in institutional use, a large-size young tom is generally chosen. This type of bird not only yields the greatest amount of meat per pound of dressed meat, but also provides meat in thick steaks, large slices and long strips that make possible a greater variety of dishes. The larger the bird the less expensive the meat to a certain point. In brief, turkey yields are higher than other poultry yields, and turkey costs less to serve.

Under Running Water

Some food jobs can be done to best advantage under running water, food specialists of the U.S. Department of Agriculture say.

To prevent tears many have learned to peel onions under water. Others know that a quick and easy way to wash a head of lettuce and separate the leaves at the same time is to cut out the white "core" or stem at the base of the head, and then let water flow in. The same method may be used to help wash and separate celery stalks.

Scraping carrots under water hastens the job because the water carries off the bits of peel as you scrape. Beets, hot from the kettle, are easily held and skinned under a cold flow of water.

As for the hard-cooked eggs for salads and cold plates, they should be cooled promptly after cooking to prevent over-cooking and help ward off the dark ring which sometimes appears around the yolk. Both cooling and shelling can be done simultaneously under the cold water faucet.

The specialists suggest cracking the egg shell by tapping at the large end where there is an air space underneath which makes it easy to get a fingerhold to start peeling off the shell. The flow of water not only cools the egg but also helps ease off the shell and any bits left on the white.

another first award*

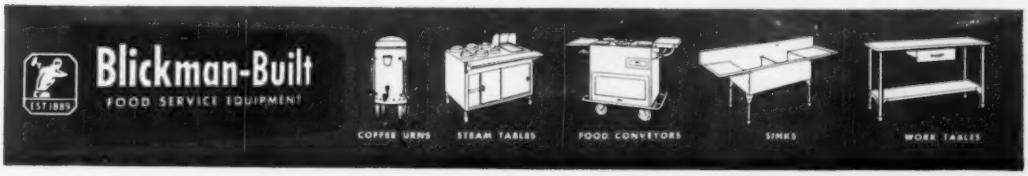
BLICKMAN FOOD SERVICE EQUIPMENT
at University of Wyoming

*Blickman-Built food service installations consistently win first awards: 2 First Awards in 1950, a First Award in 1949, a First Award in 1948 . . . in addition to numerous Merit and Honor Awards.

● *"The finest and most modern equipment"*—that was the first *"must"* set forth by the University of Wyoming for their new cafeteria and kitchen. This installation won a Grand Award in Institutions magazine's 1950 Food Service Contest. If you, too, want *"the finest and most modern"* for your food service requirements, buy "Blickman-Built" equipment. On every basis of comparison—durability, sanitation, appearance, low up-keep—it is your wisest investment.

Send for illustrated folder describing Blickman-Built food service equipment, available in single units or as complete installations.

S. BLICKMAN, INC., 1512 Gregory Avenue, Weehawken, N.J.



Menus for January 1951

Bessie Losie
St. Luke's General Hospital
Bellingham, Wash.

1
Orange Baskets
Bacon, Coffee Cake
•
Jellied Consommé
Roast Turkey, Dressing
Mashed Potatoes
Cranberry Sauce
Pickles, Celery, Olives
Asparagus Tip Salad
Plum Pudding, Hard Sauce
•
Oyster Stew
Turkey Sandwich
Potato Chips
Poinsettia Salad
Ice Cream
Fruit Cake

2
Melon
Bacon, Toast
•
Fruit Cocktail
Meat Pie With Vegetables
Steamed Potatoes
Wax Beans
Lemon Chiffon Pie
•
Cream of Mushroom Soup
Chicken and Noodles
Tossed Salad
Celery Curls
Jellied Fruit

3
Orange Juice
Soft Cooked Eggs
•
Chicken Rice Soup
Liver and Bacon
Creamed Potatoes
Harvard Beets
Bread Pudding With Raisins
•
Cream of Celery Soup
Veal Turnovers With Gravy
Mixed Vegetables
Lettuce and Tomato Salad
Raspberry Parfait

4
Applesauce
Muffins, Jelly
•
Vegetable Soup
Roast Beef
Mashed Potatoes
Baked Squash
Cinnamon Apple Tapioca
•
Cream of Tomato Soup
Cheese Soufflé With Mushroom Sauce
Escalloped Potatoes
Fruit Salad
Hot Biscuits, Jelly

5
Tomato Juice
Scrambled Eggs, Toast
•
Cream of Celery Soup
Escalloped Salmon
Baked Potatoes
Buttered Carrots
Fruit Trifle
•
Cream of Pea Soup
Crabmeat Casserole
Carrot and Raisin Slaw
Plums
Cookies

6
Sliced Bananas
French Toast, Jelly
•
Chicken Barley Soup
Meat Balls With Gravy
Mashed Potatoes
Mixed Vegetables
Gingerbread With Lemon Sauce
•
Cream of Corn Soup
Corn Fritters With Bacon
Cooked Vegetable Salad
Prune Whip With Custard Sauce

7
Grapefruit Half
Bacon, Toast, Jelly
•
Consommé
Chicken Fricassee
Candied Sweet Potatoes
Carrots
Butterscotch Sundae
•
Clam Chowder
Cold Cuts
Baked Potatoes
Tomato Aspic Vegetable Salad
Fresh Raspberries, Cake

8
Kadota Figs
Coffee Cake, Jelly
•
Scotch Broth
Meat Loaf With Gravy
Mashed Potatoes
Asparagus
Apple Tapioca
•
Cream of Vegetable Soup
Hamburgers on Toasted Buns
Cabbage Slaw With Pineapple
Caramel Custard

9
Baked Apple
Scrambled Eggs, Toast
•
Vegetable Soup
Small Broiled Steak
Potatoes With Gravy
Stewed Tomatoes
Lemon Graham Cracker Pudding
•
Broth
Italian Spaghetti With Tiny Meat Balls
Pickled Beet Salad
Plums
Cookies

10
Stewed Peaches
Soft Cooked Eggs
•
Chicken Barley Soup
Veal Chops
Potatoes au Gratin
Stewed Tomatoes
Apple Upside-Down Cake
•
Cream of Tomato Soup
Spanish Omelet
Macaroni and Cheese
Lettuce With 1000 Island Dressing
Pears in Lime Gelatin

11
Tomato Juice
French Toast, Jelly
•
Vegetable Soup
Swiss Steak
Mashed Potatoes
Buttered Carrots
Chocolate Pudding With Whipped Cream
•
Broth
Escalloped Sweet Potatoes
Apples With Ham
Jellied Vegetable Salad
Lemon Snow With Custard Sauce

12
Stewed Prunes
Scrambled Eggs
•
Tomato-Rice Soup
Fried Oysters
Escalloped Potatoes
Harvard Beets
Custard
•
Cream of Pea Soup
Deviled Egg Sandwich
Pear and Cottage Cheese Salad
Raspberries
Sponge Cake

13
Sliced Bananas
Muffins, Jelly
•
Scotch Broth
Roast Beef
Mashed Potatoes
Green Beans Pimiento
Butterscotch Date Pudding
•
Cream of Corn Soup
Jellied Veal Loaf
Creamed Potatoes
Cooked Vegetable Salad
Cherries
Cookies

14
Grapefruit Sections
Bacon Curls, Jelly
•
Consommé
Baked Ham
Candied Sweet Potatoes
Frozen Peas
Chocolate Sundae
•
Oyster Stew
Chicken Salad
Asparagus Tips
Sliced Tomatoes
Frozen Peaches
Cake

15
Grapefruit Juice
Coffee Cake, Jelly
•
Chicken Noodle Soup
Braised Short Ribs of Beef
Mashed Potatoes
Creamed Corn
Apple Cobbler With Cream
•
Cream of Vegetable Soup
Hamburger Pie
Asparagus Cuts
Lettuce With Dressing
Pears
Angel Food

16
Sliced Bananas
Toast, Honey
•
Vegetable Soup
Veal Cutlets
Potatoes au Gratin
Creamed Celery
Strawberry Shortcake
•
Broth
Spanish Rice With Bacon
Pear and Cottage Cheese Salad
Cinnamon Apples

17
Prunes
Soft Cooked Eggs
•
Chicken Barley Soup
Lamb Patties With Bacon
Riced Potatoes
Harvard Beets
Marble Pudding
•
Cream of Tomato Soup
Egg Salad Sandwich
Stuffed Baked Potatoes
Mexican Salad
Pears
Muffins

18
Orange Halves
Poached Eggs, Toast
•
Vegetable Soup
Meat Loaf With Gravy
Mashed Potatoes
Buttered Carrots
Blancmange
•
Cream of Corn Soup
Salisbury Steak
Baked Potatoes
Vegetable Salad
Apple Crisp With Hard Sauce

19
Apple Juice
Soft Boiled Eggs
•
Tomato-Noodle Soup
Baked Salmon
Creamed Potatoes
Stewed Tomtoes
Banana Cranberry Whip
•
Cream of Pea Soup
Crabmeat Casserole
Stuffed Baked Potatoes
Green Bean Salad
Stewed Apricots
Cookies

20
Grapefruit Juice
French Toast, Jelly
•
Chicken Rice Soup
Roast Beef
Mashed Potatoes
Baked Squash
Fruit Trifle
•
Cream of Celery Soup
Chicken Pie
Cabbage Slaw
Plums
Cookies

21
Stewed Apricots
Bacon Curls, Brioche
•
Consommé
Fried Chicken
Creamed Potatoes
Carrots
Molded Fruit Salad
Strawberry Sundae
•
Clam Chowder
Crab Salad
Baked Potatoes
Celery and Olives
Tossed Salad
Peaches
Cake

22
Apple Juice
Poached Eggs, Toast
•
Scotch Broth
Broiled Hamburgers
Steamed Potatoes
Stewed Tomatoes
Chocolate Fudge Pudding
•
Cream of Vegetable Soup
Stuffed Acorn Squash
Wax Beans
Vegetable Salad
Fruit Gelatin
Cookies

23
Sliced Bananas
Scrambled Eggs, Toast
•
Oxtail Soup
Roast Beef
Baked Potatoes
Stewed Tomatoes
Lemon Chiffon Pie
•
Cream of Celery Soup
Cold Meat
Escalloped Potatoes
Cabbage, Carrot and Pineapple Slaw
Lemon Snow With Custard Sauce

24
Stewed Prunes
Scrambled Eggs
•
Chicken Barley Soup
Liver and Bacon
Baked Potatoes
Escalloped Corn
Peach Custard
•
Cream of Corn Soup
Sautéed Chopped Sirloin and Mushrooms on Toast
Lettuce With Chiffonade Dressing
Baked Apples With Mince Meat

25
Applesauce
Poached Eggs, Toast
•
Scotch Broth
Brunswick Stew
Steamed Potatoes
Wax Beans
Peach Cobbler
•
Cream of Carrot Soup
Creamed Chip Beef on Hot Biscuits
Waldorf Salad
Pineapple Sauce

26
Tomato Juice
Raisin Bread Toast
•
Vegetable Soup
Finnan Haddie With Egg Sauce
Mashed Potatoes
Carrots
Lemon Chiffon Tarts
•
Cream of Pea Soup
Cheese Soufflé With Mushroom Sauce
Escalloped Potatoes
Carrot Raisin Slaw
Vanilla Whip

27
Grapefruit Juice
Poached Eggs, Jam
•
Chicken Noodle Soup
Meat Balls With Gravy
Steamed Potatoes
Diced Squash
Apple Tapioca
•
Cream of Corn Soup
Chicken and Noodle Casserole
Cooked Vegetable Salad
Fruit Compote

28
Sliced Oranges
Bacon, Toast, Jam
•
Fruit Cocktail
Baked Ham
Glazed Sweet Potatoes
Spinach With Lemon
Chocolate Sundae
•
Potato Chowder
Ham Sandwich
Potato Salad
Celery Curls
Peaches
Cake

29
Baked Apples
Muffins, Jelly
•
Split Pea Soup
Salisbury Steaks
Oven Fried Potatoes
Mixed Vegetables
Pineapple Rice
•
Cream of Asparagus Soup
Veal Chop Suey
Buttered Rice
Lettuce With French Dressing
Pineapple and Plum Compote
Cookies

30
Grapefruit Sections
Bacon and Toast
•
Consommé
Stuffed Veal Chops
Creamed Potatoes
Beets
Tossed Salad
Fruit Sundae
•
Corn Chowder
Cold Meats
Potato Salad
Stuffed Celery
Frozen Peaches
Cake

31 Kadota Figs, Soft Cooked Eggs • Chicken Rice Soup, Lamb Stew, Steamed Potatoes, Baked Squash, Apple Cobbler • Cream of Corn Soup, Macaroni and Cheese, Asparagus Tips, Jellied Tomato Juice Salad, Plums, Cookies

Ready-to-eat or cooked cereals are offered on all breakfast menus.

What the administrator needs to know about

The Rôle of the Mechanical Engineer

GUY B. PANERO
Consulting Engineer
New York City

TWO facts make the consideration of hospital mechanical systems particularly important at this time. The first is that the volume of hospital construction is on the increase and likely to stay high for at least five years. The second consideration is that mechanical systems of a modern hospital—heating, plumbing, ventilating, air conditioning, light and power—account for from 25 to 40 per cent of total cost. In addition, a sizable part of the yearly budget must be set aside for operation and maintenance of mechanical equipment.

HOSPITALS MUST SAVE MONEY

Hospitals have a special need for saving money. Unlike industrial organizations they seldom, if ever, can make a profit, and their funds are limited. Of the 1,423,529 beds reported in a 1948 survey, nearly 1,373,000, or 95 per cent, were either governmental, church or nonprofit organizations.

True enough, you say, but where does the administrator come into the engineering picture? He knows nothing about heat coefficients, design temperatures, vacuum return systems or boiler horsepower. The chances are he can't even work a slide rule.

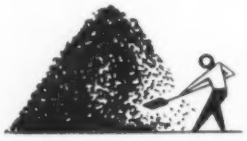
Nevertheless, the administrator and his staff, because they know their requirements better than anyone else, can offer valuable assistance to the engineer. The staff knows how well the mechanical system of the present hospital has functioned and what it would like in the new one. This is information the mechanical engineer should know, for there is no standard formula for designing a good hospital. Each project is an individual problem, although there are certain general practices to be followed.

Most hospital administrators or building committees have had little experience in dealing with architects and engineers. The first time they face the problem of building a new hospital may even be the last. An understanding of the engineer's rôle would therefore be helpful to the administrator and enable him to make constructive contributions. Much of what will be said here applies to mechanical systems in general, but there are some specific remarks on hospital boiler plants, which have been the subject of many warm arguments.

WANT PART IN PLANNING

I asked some of my engineering colleagues what they would like to say most to hospital administrators. Invariably they replied to this effect: "Tell them we'd like to take part in planning as early as possible. It's really here that we can be of most service."

There are many examples of this. Suppose the building committee is trying to decide whether to have its own laundry facilities. After other considerations are discussed, the engineer may point out that the boiler installation being planned can supply steam for the laundry at a very low cost. Moreover, the laundry's use of additional steam may make summer operation of the hospital's boiler plant more economical.



A further reason for having the engineer take part in early planning is that he must estimate the steam load at a very early date. The architect needs this information to determine the size and design of the boiler house.

POINTS TO CONSIDER

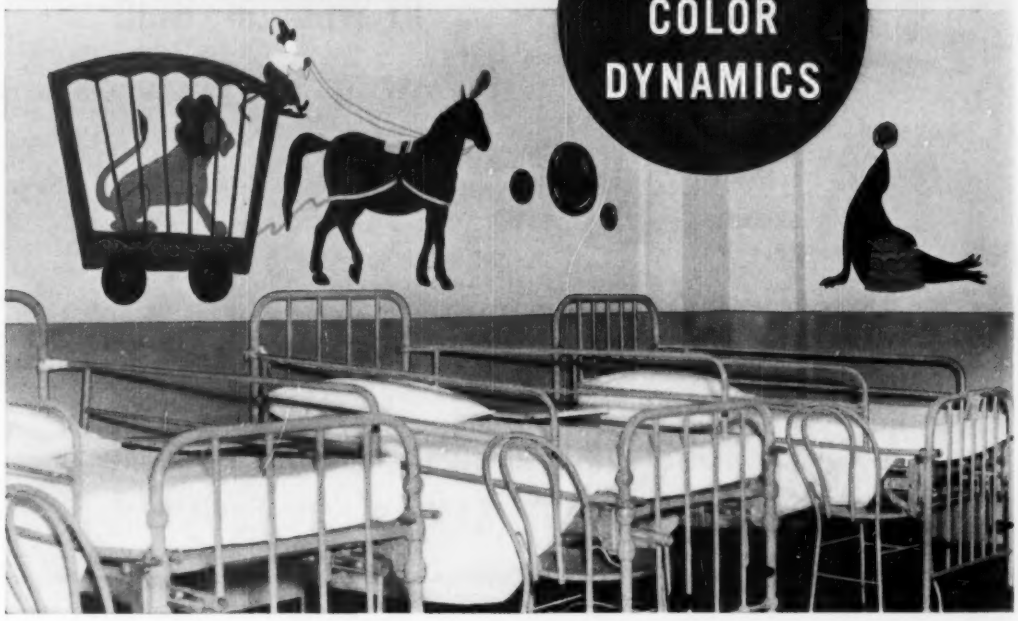
In order to cooperate successfully with the engineer, the administrator and building committee should know the considerations that influence the design and choice of mechanical equipment. Here are some:

1. Necessity for continuous operation.
2. Initial cost.
3. Cost of operation and maintenance, including labor.
4. Freedom from noise and dirt in operation.
5. Equipment capable of matching long life of building.
6. Flexibility to allow for expansion or alteration.

Most of these factors operate in the design of all buildings, but some of them have special significance for hospitals. The special need for economy has already been pointed out. The necessity for continuous operation is obvious, but frequently results in extreme caution and costly "over-design." The administrator can use his knowledge to moderate precautions. His experience may show, for example, that fuel deliveries for many years have been so dependable that only nominal storage is required, whereas the engineer may have recommended an unusually large storage space as precaution against emergencies.

Banish gloom, brighten cheerless, tired-looking rooms, modernize your entire hospital with fresh, new ideas

. . . with Pittsburgh COLOR DYNAMICS



Now Give Patients and Staff Alike a Whole New World of Helpful Color . . . with Scientific Accuracy

HOSPITAL executives are becoming increasingly aware of the very real therapeutic value—both physical and psychological—when color is used for functional as well as decorative purposes.

● **Patients** and hospital staff alike are benefited by the employment of colors which, besides looking attractive, actually exert a noticeable influence on the people who live with them.

● **This fact accounts** for the tremendous interest in Pittsburgh COLOR DYNAMICS for the hospital field.

● **The use of COLOR DYNAMICS** in many institutions has resulted in speedier recovery for patients and increased efficiency of medical and nursing staffs.

● **It should be emphasized** that COLOR DYNAMICS is *not* just an interior decorating scheme. It's a scientific use of the knowledge of human reactions to the *energy* which colors are known to possess. Tests have proved that certain colors or combinations of colors stimulate or relax, others cheer or depress.

● **By the use of** COLOR DYNAMICS, patients' rooms have been given arrangements that aid convalescence. Color can be used to relieve eye-fatigue and tension in operating rooms, and claustrophobia in labor rooms.

● **With COLOR DYNAMICS** you can also make nurses' stations, hospital offices and living quarters more congenial and suitable for their particular functions.

● **Plan to use this** modern painting method next time you paint and obtain these benefits for your institution.

We'll make a COLOR DYNAMICS engineering study—FREE!

● For a complete explanation of COLOR DYNAMICS and how to use it, send for our FREE profusely illustrated booklet which contains numerous examples of its use.

Better still, we'll gladly make a scientific color engineering study of your hospital, without cost or obligation to you. We have trained color experts at each of our 75 warehouses. Call your nearest Pittsburgh Plate Glass Company branch and we'll gladly send one of these representatives to see you at your convenience. Or mail this coupon.

SEND FOR A COPY OF THIS BOOK!

Pittsburgh Plate Glass Co., Paint Div., Dept. MH-120, Pittsburgh 22, Pa.

☐ Please send me a FREE copy of your booklet *"Color Dynamics."*

☐ Please have your representative call for a Color Dynamics survey without obligation on our part.

Name _____

Street _____

City _____ County _____ State _____

PITTSBURGH PAINTS

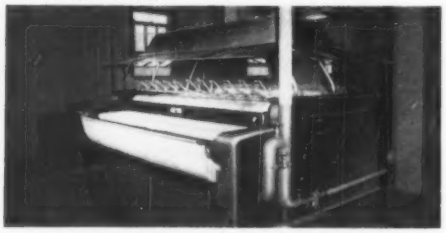
PAINTS • GLASS • CHEMICALS • BRUSHES • PLASTICS

PITTSBURGH PLATE GLASS COMPANY

Witness the Wooster Community Hospital of Wooster, Ohio

A 75-Bed Institution Planned for Modern, Efficient Linen Service with HOFFMAN Laundry Equipment

Three sizes of Hoffman "Silver Crest" washers provide flexibility for any combination of soiled linens. Extractors are 40-inch "Open Top" and 17-inch "Vorsec" (not shown).



Fast, high-quality production of flatwork is accomplished on this 4-roll, 110-inch Hoffman Ironer, complete with canopy . . . faster drying with "Greyhound" tumbler (not shown).

Recent opening of this private, non-profit Wooster hospital emphasizes the *completeness* of Hoffman laundry equipment service. Even the smallest laundry is big in importance. That's why Hoffman is prepared to furnish the right size and type of machinery for laundries with smaller linen loads. And offers the same engineering survey and planning assistance provided to larger institutions. Scores of medium- and small-size hospitals have gained top linen output, lowest operating cost and maximum convenience by calling on Hoffman's specialized engineering counsel. Request it for your laundry planning.

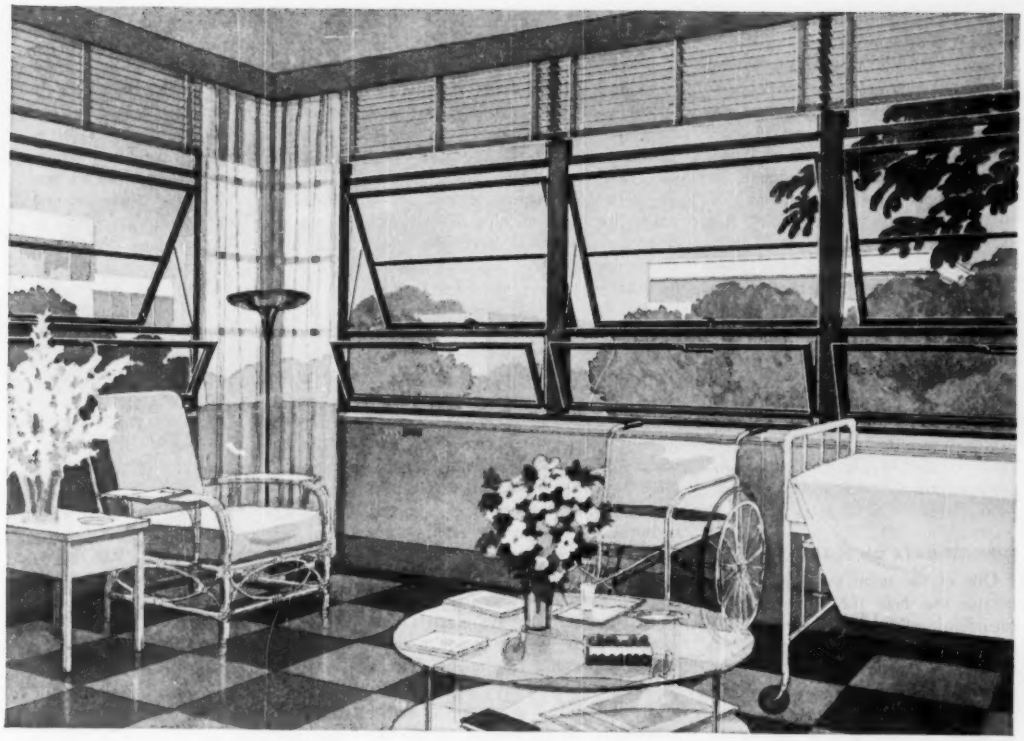
For New or Modernized Laundries FREE Engineering Survey

Analyzes your laundry costs; surveys your linen requirements and suggests control schedules; furnishes new layout plans; recommends equipment to help you save floor space, time, labor, fuel, supplies and linen.

INSTITUTIONAL ... DIVISION

Hoffman

U. S. HOFFMAN MACHINERY CORP. 105 FOURTH AVENUE, NEW YORK 3, N. Y.



Here's Why It's a Better Hospital Window

Especially Designed for Hospitals

The Lupton "Master" Aluminum Window opens up new opportunities in window planning for hospitals. From a design standpoint, it offers better appearance, minimum infiltration and a greater adaptability to modern building design. From a construction standpoint, it sets new standards of high durability and low maintenance costs.

Better—because it's designed for hospitals to meet hospital daylighting and ventilating requirements . . .

Better—because it's made of special heat-treated aluminum alloy . . .

Better—because it's the newest member of a great family of metal windows . . . a family of windows that has grown up through more than 40 years of service to the building industry . . .

It's the new Lupton "Master" Aluminum Window. Requires no painting. Needs no costly repairs. Ventilator corners are welded for added strength. Both frame and ventilator sections are 1-5/8" deep. Ventilators fit snug and tight—naturally, without forcing—with full 5/16" overlapping contact. You get all the advantages of lightweight aluminum with finer appearance, improved natural lighting and controlled, draftless ventilation.

Your hospital architect knows Lupton Metal Windows. We will be glad to supply full details on this newest Lupton Window. Write for Data Sheets today.

MICHAEL FLYNN MANUFACTURING COMPANY
700 East Godfrey Avenue, Philadelphia 24, Penna.
Member of the Metal Window Institute & Aluminum Window Mfrs. Assn.

LUPTON
METAL WINDOWS

Just as frequently, however, it is the administrator who advocates additional "safety" factors in mechanical systems. If he has had experience with a poorly designed and inadequate heating system, for example, he wants to make sure that the new hospital will have enough heat. Using standards of the American Society of Heating and Ventilating Engineers will accomplish this, the engineer will say. But the administrator may want to add from 10 to 25 per cent to these recommendations for "safety." This increases the amount of radiation, which in turn determines boiler size, and alters costs throughout the heating system. The A.S.H.V.E. standards are already adequate for "safety," and increasing them causes overheating, which some consultants claim is one of the commonest and costliest mistakes that is made in hospital design.

FURNISH DATA ON PLANS

One of the main ways the administrator can help the engineer is by furnishing as nearly complete data as possible on operating plans for the new hospital. If you stop to think about it a minute, you can see how complex it is to estimate the amount of steam a hospital will use. It depends on how many hours the laundry is operated, how much sterilization is done—to mention but two things. The time of day these tasks are performed is also important. If sterilization and laundry loads occur at the same time, they will require greater steam capacity. If they occur at different times, a lower capacity will suffice. The engineer is interested in finding the maximum hourly load, and an accurate and complete work schedule of the future hospital is extremely helpful.

As has been pointed out, a large number of hospitals are run by local, state and federal agencies. Because of low civil service ratings, these institutions frequently have difficulty obtaining qualified maintenance personnel. All mechanical equipment, but particularly the boiler plant, should be designed with ease of operation and maintenance in mind. Here, again, the administrator can tell the engineer the qualifications of his operating personnel.

A number of trends in hospital design have given added importance to the mechanical aspects of the building. Small and medium-sized hospitals tend to locate in suburban areas, and this means all equipment must function flawlessly. These hospitals prefer to be completely independent insofar as utilities are concerned. Buildings last longer today than formerly and therefore require longer-lasting mechanical equipment, or equipment that can readily be replaced. Yet, because the need for hospital service grows yearly, the building must have a mechanical system capable of expansion.

Other trends have caused an increase in steam and electrical loads. Ventilation systems have improved generally, but especially in laboratories, which have become a standard part of every new hospital. Fresh air must be brought in to replace exhausted air and should be conditioned, although in some cases part of it can be recirculated. A wider use of therapy equipment has added to steam and power consumption. A completely equipped hydrotherapy section, for example, requires steam to heat the water and power to swirl it.

To offset increased steam usage, more attention is being given to insulation, both of the building itself and of pipes and equipment. Use is also being made of feed water heaters in the boiler plant to cut cost of steam generation. These heaters utilize exhaust steam to preheat water before it goes into the boiler. In addition, all returns and condensate are brought back to the feed water heater, and their heat is "salvaged." To save electrical power, boiler house auxiliaries can frequently be driven by steam. It is the engineer's job to study electric *v.* steam driven auxiliaries, feed water heaters and similar "conservation" equipment to see if the saving justifies the cost.

The proper use of conservation and control equipment can frequently mean the difference between an efficient and an inefficient boiler plant. We were surprised to receive a report from a person who visits a large number of hospitals each year that he found many boiler plants lacking in essential instruments for checking boiler operation. Here are some basic instruments which we recommend and install on practically all projects: steam pressure recorder, draft gauges, steam flow-air flow meters, CO_2 recorder and flue glass temperature recorder, smoke alarms and outside wet and dry bulb temperature recorder. The safe and efficient operation made possible by these instruments more than justifies their moderate initial cost.

Some provision should also be made for fuel measuring devices—gauges for oil and scales for coal. The rate of fuel consumption must be accurately known if any check is to be made on combustion efficiency.

One of the aims of good hospital design which we mentioned earlier was flexibility to allow for expansion and alteration. This applies particularly to fuel for the boiler plant. Provisions can be made at the start for a boiler to burn either oil or coal, the changeover from one to the other requiring only a few hours. If this flexibility isn't provided for initially, however, the changeover can be costly or even impracticable to accomplish later. In some areas consideration should also be given to using gas or oil. Where these fuels are economical, they have proved popular because they eliminate hand stoking necessary with coal. But overhead bunker storage of coal with a gravity-fed stoker also answers the labor problem for communities that use coal.

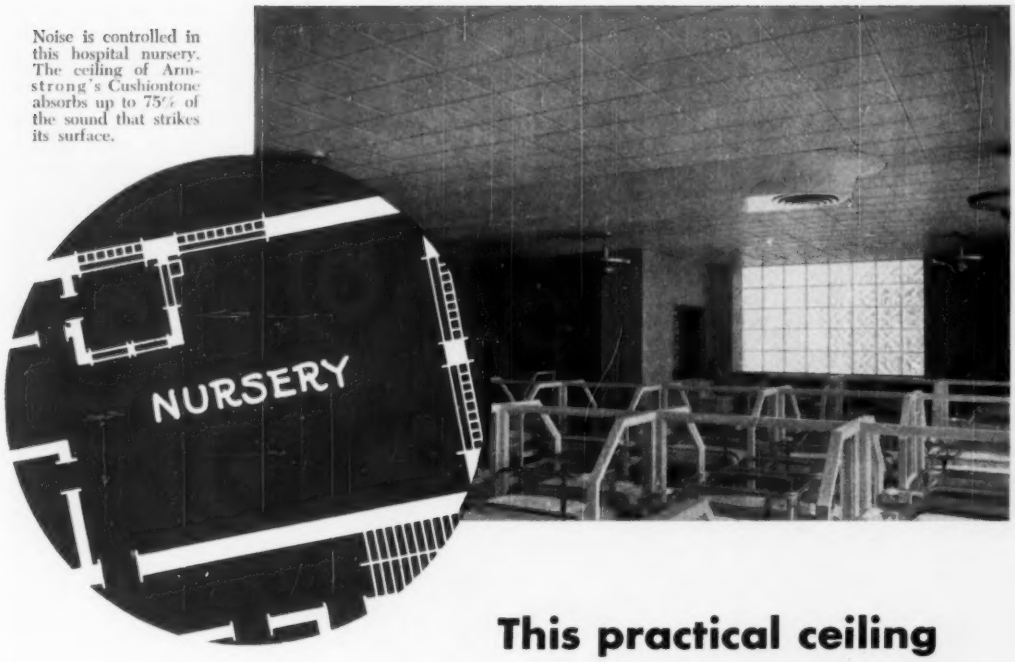
PERFORMS MANY FUNCTIONS

The boiler plant of a hospital performs many functions, furnishing hot water or steam for heating, sterilization, kitchens, and the laundry (about 75 per cent of all hospitals operate their own laundries). The kind of boiler plant and heating system which should go into any one hospital is an engineer's problem, but some of the considerations can be shown by looking at recent projects of our organization.

East Bronx Tuberculosis Hospital, New York City. This is a large municipal project on which design has been completed, although construction did not start until late last summer. A 500 bed, seven-story tuberculosis hospital, a boiler house, laundry, staff building, stewards' building, and maintenance building will be constructed first, with a 750 bed general hospital to follow immediately. At some future date, additional municipal institutions will be added.

To meet steam requirements for the two hospitals, three high-pressure boilers, each capable of generating 38,000 pounds of steam per hour, will be installed. One of the boilers will be used as a spare. Space is provided for the installation of two more boilers of the same size to meet future requirements. Still only one spare will be necessary, because it is extremely unlikely that more than one boiler will

Noise is controlled in this hospital nursery. The ceiling of Armstrong's Cushiontone absorbs up to 75% of the sound that strikes its surface.



This practical ceiling quiets nursery noise

Nobody expects to maintain absolute quiet in a nursery, but with proper acoustical treatment on ceilings, noise can be kept to a minimum. Infants can exercise their lungs with less distraction to surrounding hospital areas.

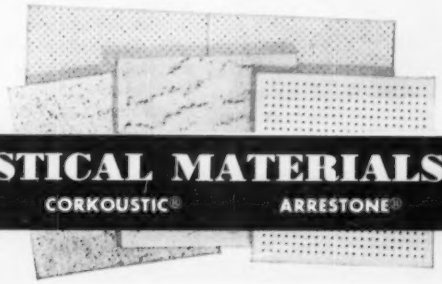
Two of the most widely used noise-quieting materials for nurseries are made by the Armstrong Cork Company—Cushiontone and Arrestone.

Armstrong's Cushiontone is especially practical because its purchase, installation, and maintenance costs are low. It's made of durable, economical wood fiber. Each square foot of Cushiontone contains 484 drilled perforations which soak up sounds instead of allowing them to reverberate throughout the room. Cushiontone is quickly applied to any flat surface by cementing or nailing. Its smooth, washable surface can be repainted without loss of acoustical efficiency.

For maximum noise-quieting efficiency, Armstrong's Arrestone is an ideal choice. This is a perforated metal pan unit containing a mineral wool pad which absorbs 85% of the noise that strikes it. Arrestone is incombustible. The pans are made of steel and finished with baked-on enamel. Units are easy to clean and repaint. They can be removed and relocated easily to provide access to piping and ventilating ducts.

There's an Armstrong material to meet every sound-conditioning need in hospitals. Armstrong's Travertone is ideal where acoustical ceilings of distinctive beauty are desired. Armstrong's Corkoustic meets requirements for a ceiling that is highly moisture resistant. For full details, see your Armstrong acoustical contractor.

FREE BOOKLET, "How to Select an Acoustical Material," contains important facts about sound conditioning. Write to Armstrong Cork Company, 5712 Stevens St., Lancaster, Pa.



ARMSTRONG'S ACOUSTICAL MATERIALS

CUSHIONTONE® TRAVERTONE* CORKOUSTIC® ARRESTONE®

*T.-M. REG. APPLIED FOR

be out at a time. The boilers are the two-drum, bent tube type, and will supply steam at 125 pounds' pressure. They are designed to operate at from 50 to 225 per cent of capacity in order to handle varying seasonal loads efficiently.

It was possible in this case to use "fixed-design" boilers, costing approximately 15 to 20 per cent less than specially designed units. Another interesting economy measure was the recovery of heat from laundry water. This is not always feasible, but because of the large volume and the fact that some of it (from the tuberculosis hospital) will be done at a very high temperature (180° F.), it proved economical to install heat exchangers.

Meadowbrook Hospital, Mineola, N.Y. This project involves a $10 million program to add 400 beds to the county's present hospital. The present 200 bed hospital is supplied by two 300 horse power boilers, one operating at 150 per cent of capacity with one as a spare. To meet the needs of the 400 bed addition and provide for future loads, two 500 horse power boilers will be installed. Operating at 200 per cent of capacity, they will supply 2000 boiler horse power, giving the plant a total of 2450 horsepower and one spare boiler.

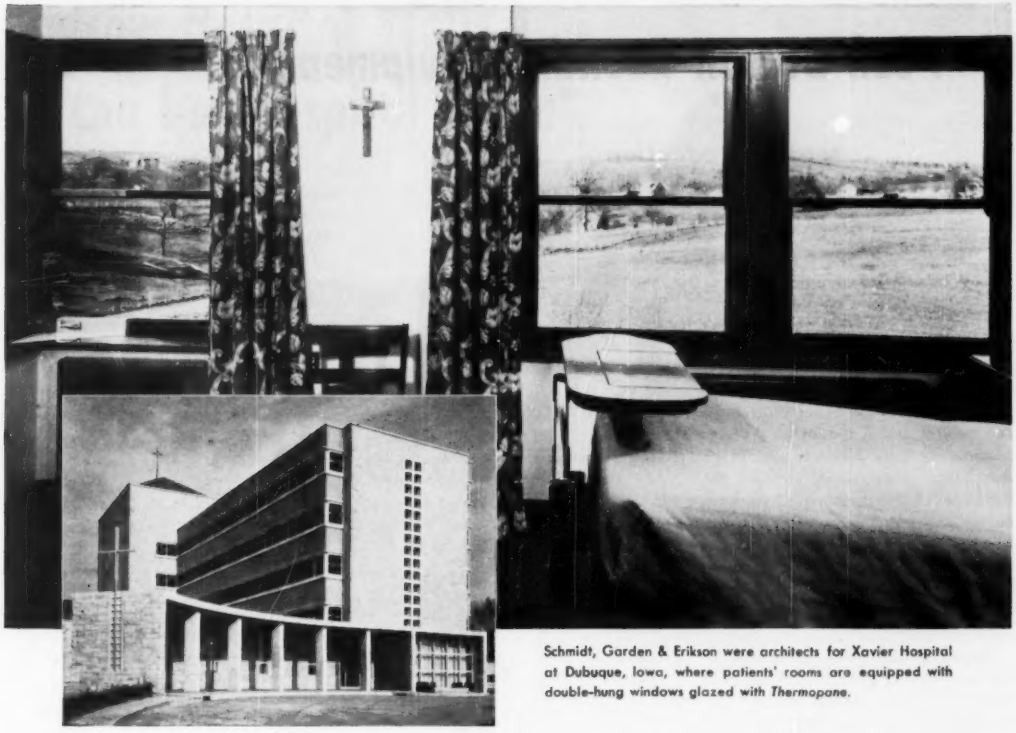
This is more than adequate for present needs, but the county plans to construct a future building, and the steam requirements can be met by the hospital boiler plant. Pending future construction, efficiency will be maintained by operating only two of the four boilers.

Veterans Administration Neuropsychiatric Hospital, Pittsburgh. Construction of this 1000 bed hospital started in January and is expected to be completed in two years. Unlike the two previous projects, this one had no future requirements to be considered. The steam load for this large 16 building institution will probably remain static. These needs will be met by four 350 horse power, three-drum, bent tube boilers. They will operate at 200 per cent of rating, with one used as a spare, and will produce steam at 110 pounds' pressure. Light summer loads can be met by operating the boilers as low as 50 per cent of rating.

In this area coal, of course, is the most economical fuel. Although it is likely to produce more soot than does oil, the isolation of the boiler house from the remainder of the hospital lessened this objection. The use of a separate, isolated building for boilers proves most satisfactory for large projects. This puts noise, dirt or smells that may result from fuel deliveries at a good distance from patients.

Because of the large number of scattered buildings to be serviced, steam heating was chosen for this project. Steam distribution was easier than hot water circulation, although the operating suites and some psychiatric wards have radiant heating.

These are some of the things the administrator will want to know when he is faced with building a new hospital. With long-range construction programs now underway, and with the demand for hospital service growing, the "expansion problem" is likely to confront every administrator at one time in his career. A basic knowledge of the engineer's rôle enables the administrator to perform his task better and make positive contributions. Cooperation on the administrator-architect-engineer team is essential if hospital plants are to keep abreast of the great strides being made in medicine and surgery.



Schmidt, Garden & Erikson were architects for Xavier Hospital at Dubuque, Iowa, where patients' rooms are equipped with double-hung windows glazed with *Thermopane*.

One Thing Patients and Superintendents Agree on!

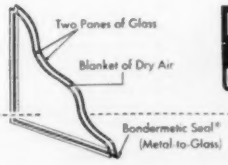
They both want the patients happy! And the patients want plenty of view and light. But superintendents worry about drafts, chills and extra demands on the heating system. At the new Xavier Hospital in Dubuque, Iowa, they have the solution.

The windows are *Thermopane*® insulating glass. The two panes with ½" dry air hermetically sealed between provide approximately twice the thermal insulation of single glass. Result, heating costs are greatly reduced. Because *Thermopane* also lowers air conditioning costs in summer, it is becoming standard for operating sections, nurseries and laboratories.

However, anyone responsible for hospital design or maintenance should keep in mind that when walls are *Thermopane*, costs of exterior construction, finishing and interior decorating are eliminated. On a square foot basis, you'll find it an economical wall to build. Write for our 24-page illustrated booklet, "Daylighting for Hospitals", and *Thermopane* literature.

*®

FOR BETTER VISION SPECIFY THERMOPANE
MADE WITH POLISHED PLATE GLASS



LOF GLASS

Thermopane

MADE ONLY BY LIBBEY-OWENS-FORD GLASS COMPANY
59125 Nicholas Building, Toledo 3, Ohio

Push-Button Laundry Equipment

speeds production

and saves labor

THE main objective of New York City officials in designing the Welfare Island laundry was to process linens from all the hospitals on Welfare Island in the most scientific manner possible and at the lowest cost per pound. The new laundry, said to be the largest hospital laundry in the world, will serve the needs of patients, nurses and personnel of City Hospital, Metropolitan Hospital, New York City Cancer Institute, Goldwater Memorial Hospital, City Home, Central Nurses' Residence, and Reception and Welfare Island Dispensary.

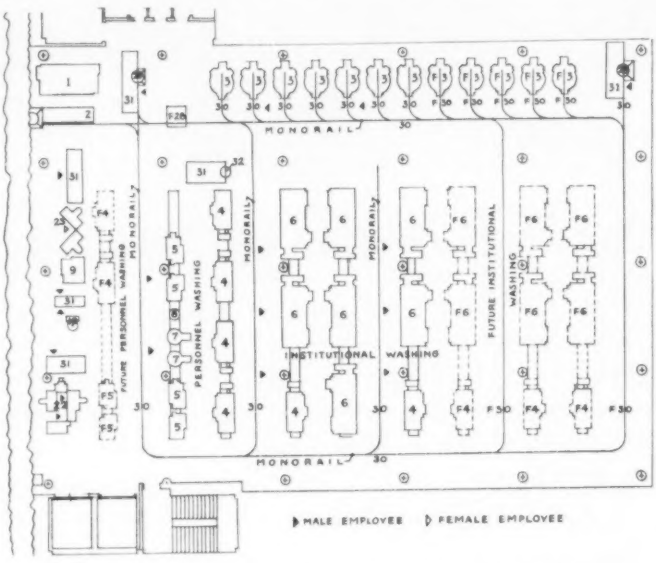
Approximately 6800 tons of laundry per year, covering the requirements of 6683 beds, is the immediate goal. Provisions for expansion will take care of 4200 additional tons per year from a total of 8683 beds. It is estimated that the average patient in general hospitals requires from 14 to 17 pounds of clean, sanitary linen per day; patients in chronic disease wards may require from 30 to 50 pounds per day, including operating, reception and dispensary linen. Advanced medical and nursing technics also require greater poundage of special linen items. On Welfare Island some 200 different types, shapes and sizes will be processed.

Because labor is the biggest single item of cost in processing laundry work, this laundry was designed as a gravity flow plant with push-button automatically controlled equipment to obtain the greatest number of pounds processed per operator in the least amount of square feet of floor space. Full advantage has been taken of the gravity flow of work from one operation to the other.

The fact that eventually 11,000 tons of laundry work will be handled means that someone must be paid to carry this work from one operation to another. On Welfare Island a great amount of the carrying has been eliminated by the design of the building, push-button automatically controlled unloading washers, push-button automatically controlled unloading extractors, push-button automatically controlled folders for sheets and pillow cases, and push-button automatically controlled stackers for hand towels and other small flat pieces. Such equipment not only contributes to a material saving in labor cost per ton processed, but ensures corresponding savings in supplies, water, steam and electricity.

The laundry work is received by motor truck from the various hospitals and is delivered in baskets to the street floor of the laundry. From here it is carried by elevator to the receiving room on the third floor.

Here the soiled linen is sorted and classified as to size and type, *i.e.* sheets, pillow cases, towels, personal wearing apparel, doctors' coats and pants, nurses' uniforms. Personal work belonging to the personnel is marked on this floor and new linen is marked



Layout of part of the second floor of the Welfare Island laundry.

KEY TO EQUIPMENT

1. 42x120 inch drying tumbler
F1. 42x120 inch drying tumbler (future)
2. Tables with chute to first floor
F2. Tables with chute to first floor (future)
3. 50 inch extractor
F3. 50 inch extractor (future)
4. 42x64 inch washer hopper from third floor over
F4. 42x64 inch washer hopper (future)
5. 42x36 inch washer
F5. 42x36 inch washer (future)
6. 54x108 inch washer hopper from third floor over
F6. 54x108 inch washer (future)
7. 30 inch U.P. extractor
8. 50 gallon starch cooker
9. Handkerchief press
10. Hosiery dryer
11. 36x30 tumbler
12. 24 inch starch extractor
13. 3 - 24x24 inch wash tubs
14. 120 inch 6 roll flatwork ironer and feeding device
15. Coat presses
16. Coats and pants auxiliary press
17. Pants press
18. Pajama press
19. Miscellaneous press
20. Uniform press
21. Miscellaneous press
22. Shirt presses
23. Collar press
24. Ironing board
25. Sewing table and button machine
26. Serving machine
27. Sorting bins
28. Chute to 34x72 inch cond. tumbler on first floor
F28. Chute to 34x72 inch cond. tumbler on first floor (future)
29. Chute to 60x96 inch cond. tumbler on first floor
30. Monorail system and hoist (provide 6 hoists)
F30. Monorail system and hoist (future)
31. Table
32. Chute from third floor

Now Hospital Walls can be "Hospital Clean"

AND BEAUTIFUL, TOO

WITH WONDERFUL,

NEW Glendura® SOIL-PROOF WALLCOVERING *by* IMPERIAL

Scientifically developed with hospitals in mind, GLENDURA is a sensational new soil-proof wallcovering that will change ordinary walls into cheerful, friendly walls. It has beauty... durability . . . ease of application . . . and easy, economical maintenance built right into it,

because it's "Beauty in Armor."

Every color particle that gives GLENDURA Soil-Proof Wallcovering by Imperial the soft water-color beauty of finest wallpapers is protected by a substance that stains can't penetrate. Even stubborn stains such as triple-dye, mercurochrome, blood, ink and lipstick will not sink into GLENDURA. They stay on the surface where they can be harmlessly removed by soap and water, alcohol or bleach—as easily as soil is removed from a window pane.

GLENDURA, created by the makers of famous Imperial *Washable* Wallpapers, is vermin-proof and will not support bacteria. It hangs as easily as wallpaper. Its scrubbable beauty is guaranteed for three years. Available in a wide variety of colorful patterns and exquisite tints.

PROVE Glendura's remarkable cleanability to yourself. Fill out and mail this coupon today!

"Beauty in Armor" **protects GLENDURA's delicate water-color appearance against**

Food Stains

Lipstick Smears

Medicine Stains

Ink Marks

IMPERIAL PAPER AND COLOR CORPORATION
Dept. MH-2, Glens Falls, N. Y.

Please send me a trial sample of GLENDURA and booklet "Beauty in Armor" which gives all the facts about GLENDURA.

*Name*_____

*Position*_____

*Hospital*_____

*Address*_____

*City*_____ *Zone*____ *State*_____

and dated. Linen is then loaded into hoppers which are designed to hold the exact poundage to correspond with the size of the washers on the floor below, and the work is carried through the hoppers by gravity to the washers on the second floor.

Here are the push-button controlled automatic washers for washing soiled linen. The work is delivered to these washers from the hoppers directly over them. The washing and the washing formula are push-button automatically controlled. When the whistle blows, signaling the end of the washing cycle, the cylinder is mechanically lifted out of the washer and the wet, clean laundry is delivered into specially constructed extractor containers.

These containers, filled with the wet, clean laundry, are carried by monorail to the extractors where the excess water is removed by push-button automatically timed controls. After the excess water has been removed, these containers are again carried by monorail to the curved chutes. The bottom of these containers are opened and the damp, clean laundry is delivered to these chutes and, by gravity, conveyed to the first floor, directly back of the flatwork ironers.

On the first floor the damp, clean flatwork, delivered by chutes, is predried and conditioned in special push-button controlled conditioning tumblers. It is then ironed on the flatwork ironers and the sheets are folded automatically. Small pieces, pillow cases and hand towels, are ironed and automatically stacked. From the automatic folders and the automatic stackers, the flatwork is put in basket trucks for delivery to the shipping department.

Bath towels and articles to be dried and not ironed are carried in containers from the extractors to the tumblers by monorail located on the same floor as the extractors. After being thoroughly dried by push-button and thermostatically controlled operations, the goods are conveyed by chutes to tables on the first floor for folding and delivery to the shipping department.

Personal work and press work, such as nurses' uniforms, doctors' coats and pants, underwear and shirts, are carried in the extractor containers by monorail from the extractors to the press department on the same floor. Here are specially designed presses for such work, *i.e.* shirt presses, shaped correctly to press men's shirts, nurses' uniform presses for shaping and pressing nurses' uniforms, doctors' coats and pants presses.

A special department on the first floor is devoted to the washing, extracting, drying and processing of blankets and curtains. Here the blankets are washed in specially built slow-speed thermostatically and push-button controlled washers. They are transferred from these washers to the push-button automatically controlled unloading extractors. From the extractors the blankets are placed on frames and while in a damp condition are stretched to their original size and shape and then dried.

On the first floor a special feather cleaning room is provided. Here the soiled pillows are delivered and the feathers are removed from the ticking. The ticking cases are then sent to the laundry for laundering while the feathers are cleaned and sterilized in special sterilizing machines. After cleaning and sterilizing, the feathers are put back into the clean, or new, tickings; the pillows are then ready to be returned to the shipping department.

Conducted by Alta M. La Belle and Jane Barton

The Linen Closet Takes to Wheels

JOSEPH TURNER, M.D.
Mount Sinai Hospital
New York City

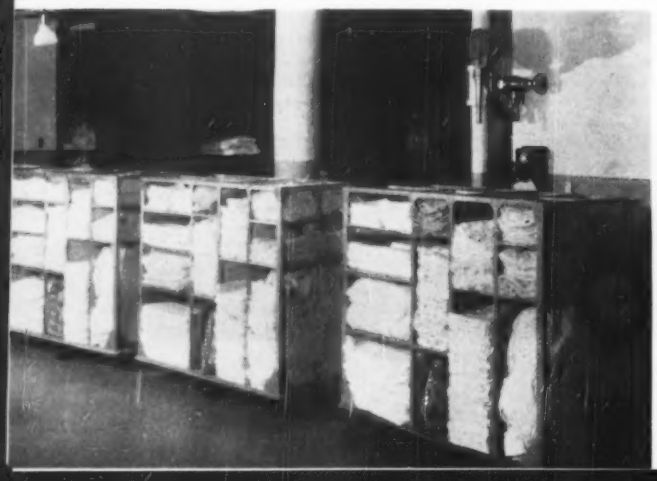
THIS is not a new creation of the 1950's. It has been in use at Mount Sinai Hospital, N.Y., for more than 20 years and was an idea at least five years before that. Yet many hospitals which could benefit by its adoption are not aware of its existence. Nor are some architects, for at a session in a course on hospital planning held in New York City this last spring, one of the most experienced hospital architects in this country listed a number of laborious and time-consuming hospital practices which were currently waiting for someone to devise better and labor-saving methods, particularly important in this time of nurse shortages. In his list was the static, fixed linen room or closet on the patients' floors. The speaker was, apparently, one of the many unaware that a "portable linen closet" had been conceived, built and put into use more than 20 years ago, that it has fulfilled its designer's expectations as a practical and effective labor-saving device.

All of the foregoing is an excuse for describing briefly at this late date, the "portable linen closet." It has been seen and copied by some, and it has been described in at least one laundry publication. At least one truck manufacturer has in recent years shown and described such a carrier in its catalog. But it still is new to many.

Briefly, it is a truck on casters designed to receive hospital linens in the laundry, to transport them to the nursing unit, to store the linens without further handling during the hours that it is being used on the nursing floor, and then to be returned to the laundry or central linen room the next day for replenishing.

The accompanying illustration describes the carrier more effectively than any word picture can do. The truck is made of a light aluminum framework divided by wire cloth into a number of compartments, the dimensions of which fit the size of the folded linens in use at the hospital. Some of the compartments extend through half the width of the truck; others extend completely through from side to side.

The carts are designed for use in nursing units of two sizes. The carts for the larger wards measure 52 inches in length, 27 inches in width, and 55 inches in height (including the height of the casters); the carts for the smaller nursing units measure 38 inches long, 22 inches wide, and 48 inches high.



The portable trucks are constructed of light aluminum framework divided by wire cloth into a number of compartments designed to fit the size of linens.

The plan is to have the trucks, one for each nursing unit, loaded with clean linens in the laundry in the afternoon. Inasmuch as the patient population in these nursing units is fairly constant, it has permitted the need for linens for each day to be determined quantitatively as a standard with reasonable accuracy. The loading of the carts is, therefore, a simple matter in the hands of laundry personnel which is familiar with these standard quantities. No requisition system is required, and no extra linens are needed except in unusual circumstances.

The carts are wheeled from the laundry to the nursing units and placed in a linen closet large enough to hold the cart. The closet has two shelves at a height above the top of the cart. Linens needed in the nursing unit during the late afternoon, evening and night are taken directly from the cart. In the morning, when the need for fresh linens is greatest for bedmaking, the cart is wheeled into the center of the large ward or corridor. Nurses then take the few steps between the bed and the cart to obtain the required supplies. Where the floor plan permits, the cart moves along with the nurse. By midday most of the linens have been dispensed, and when the hour arrives to return the cart to the laundry for replenishing, it is nearly empty or sometimes entirely so. The nurse in charge then decides whether she needs to transfer any surplus linen in the cart to the closet shelves for use until the truck returns, or whether, having an adequate supply of linens on the shelves, the truck is to be returned with its surplus.

The previous method was the traditional one of receiving a bulky linen truck, transferring its contents to the closet, sometimes arranging them uselessly in pretty geometrical patterns on shelves where they remained until the nurses or attendants used them. This required double handling and time-consuming operation which have been eliminated by the design of the truck and its method of use.

The trucks were made in the hospital shop by a machinist and tinsmith more than 20 years ago and the original trucks are still in use. Aluminum was used in the frame and wire cloth for the partitions in order to achieve lightness.

Curtin & Riley, *Architects*

BON SECOURS HOSPITAL, Methuen, Mass.

This new, completely modern 135-bed hospital is owned and operated by the Sisters of Bon Secours. A substantial contribution to operating economy and low cost maintenance is made by the use of FABRON Wall Covering in bedrooms, corridors, public spaces, offices, treatment rooms, etc.

Another FABRON Installation!

When so many of the new hospital projects going up these days insist on FABRON wall coverings as their decorative treatment — ***there must be a reason for it!***

Perhaps it's because this fabric-plastic-lacquer wall covering combines advantages no ordinary finish can duplicate — such as a decorative latitude of more than 160 patterns and colors . . . long-term durability . . . positive protection against plaster cracks . . . unlimited washability . . . easy repairability in case of damage.

Or maybe it's because of FABRON's unmatched economy — lowest on the basis of cost-per-year-of-service. Or its initial cost, well within the average budget.

More than 1100 hospitals throughout the country have already adopted FABRON, so that in considering it for ***your*** new building program you are not weighing the merits of an ***unknown*** product . . . but one that has been tested and proved by years of service.

Why not write for the new FABRON Data Sheets? They contain important information on comparative costs, the proper time to consider FABRON, how to obtain it at lowest cost, free estimating and decorating services, etc. No obligation, of course!

FABRON *helps prevent fire spread. Every roll carries the label of the Underwriters' Laboratories, Inc., sponsored by the National Board of Fire Underwriters.*

tested Underwriters' Laboratories, Inc. listed
sponsored by National Board of Fire Underwriters

fabron®

The fabric-plastic-lacquer wall covering for hospitals

FREDERIC BLANK & COMPANY, INC. • Established 1913 • 230 PARK AVENUE, NEW YORK 17, N. Y.

Represented in Canada by the Robert Simpson Company Limited—Special Contract Division

ROUNDTABLE

(*Continued from Page 75.*)

area like Chicago we don't get enough notice on our patients, and we just don't have time to collect the information. There is one phase of this problem that we didn't talk about, and that is Blue Cross. I think Blue Cross has helped a great deal in eliminating a lot of bad credit losses, because it is a great help to the public in meeting their hospital bills.

MR. JONES: What percentage of your patients have Blue Cross?

DR. MANHEIMER: I am going to guess one-third — somewhere around there.

MRS. NELSON: We checked ours just the other day, and it was 33½ per cent.

MR. JONES: In other words, what you have there is a third of your patients on whom there are very few credit and collection problems. If you had 75 per cent of the citizens in any area covered by Blue Cross, most credit and collection headaches would begin to disappear, wouldn't they?

MRS. NELSON: Dr. Manheimer and Mr. Vanderwarker have stated that it is very rare when they have a person come in from the street who is a bad risk. Well, we have this rather often. There are several industrial surgeons in our neighborhood who send cases over that are not emergencies. I have sent them back several times, or we send them over to the county hospital. It isn't so rarely that this happens.

DR. MANHEIMER: Are they known bad credit risks?

MRS. NELSON: Some are, we know. Of course, we have some OB's that come in at the last moment and we can't get out of taking them. That happens frequently.

MR. JONES: I suppose you could create some pretty bad public relations by an unintelligent, over-aggressive collection procedure.

MRS. NELSON: Our experience with a commercial agency has been good. We checked with hospitals and we checked with doctors, and we had very good reports.

DR. MANHEIMER: I think some doctors say that when they hand over a patient for collection, they rarely get that patient back. Now there must be something wrong with the collection agency if that is true.

MR. JONES: I think that depends on the collection agency. If you investigate your agency properly and agree with them on what method they are going to follow, you can't hurt your public relations very much. A deadbeat is going to be mad at you no matter what you do. But I think it is important that you should not let a credit agency sue a patient unless you have checked it with them and your credit or social service department is satisfied that it is all right to go ahead and sue.

MRS. NELSON: Our agency never sues without our O.K. Some people trump up charges against the hospital, claiming they were not well treated or were badly received. They always find some excuse.

MR. JONES: In the long run, you may gain respect for yourself by using business-like collection methods and not letting people cheat the hospital. When a person can pay, it is essential that he be made to pay. Every time you lose $15 or $16 on a bad debt, that is a day of hospital care that you can't give to some poor person who really needs help.

MR. VANDERWARKER: It is the consensus then that collection agencies should generally be employed by hospitals?

DR. MANHEIMER: Of course, the older the account the larger percentage the agency wants for collecting.

MRS. NELSON: That's right, because it is tougher to collect. In some cases, the minute a person leaves the hospital we turn it over to our collection agency. From the attitude that is taken, we know it will be a collection problem. But if a person asks for time or extension, we wouldn't think of turning it over.

MR. JONES: I was going to ask that question. Do you make arrangements for installment payments?

MRS. NELSON: Yes.

MR. JONES: Do you have people now who are paying so much a month to get their bills paid off?

DR. MANHEIMER: Yes. When a patient goes home unable to pay the bill because of some unexpected reason we make arrangements with him to pay so much a month after that. In fact, we might even finance a note for him to pay.

MR. JONES: If a man says he is going to pay so much at a certain time and he doesn't pay, do you check right away to see why he didn't pay?

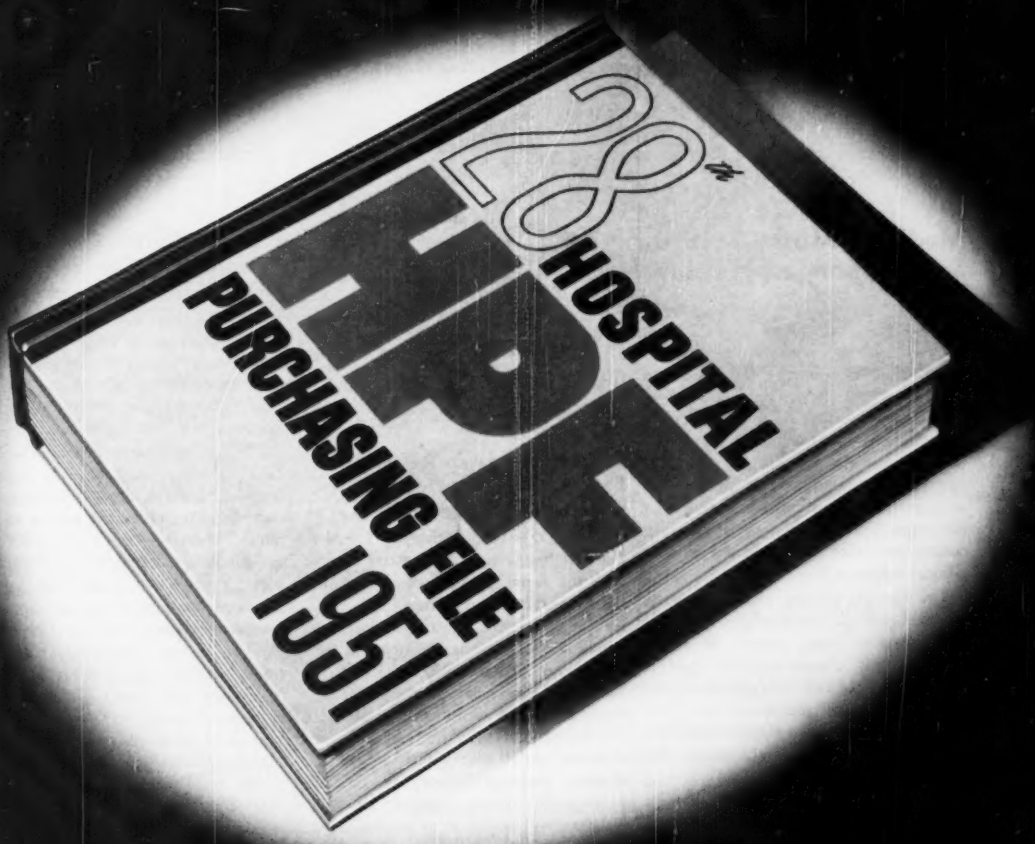
MR. VANDERWARKER: We follow it up to the best of our ability.

In their next discussion, to be published soon, members of the round table group will take up the subject of fire safety—ED.

NOW

—a new assistant

The 28th Edition of Hospital Purchasing File is now complete and in the process of distribution to hospitals. When your copy arrives, welcome it as a new assistant fresh with new ideas, full of knowledge! Give it an honored place at your own desk. Call on it for its wealth of information about sources of supply. Look to it for the catalogs of nearly 300 manufacturers most eager to serve you well. Teach your department heads to look in HPF **first.** Make HPF your **first** assistant whenever a purchase is to be made.



NEWS DIGEST

A.C.S. Standardization Conference . . . Dr. MacEachern Retires . . . A.H.A. Reports Largest Convention Attendance . . . Government Orders Cut in Use of Aluminum . . . Social Security Ruling Clarified . . . Fall Meeting Reports

Medicine Must Catch Up With Social Changes, Hawley Tells A.C.S.

BOSTON.—Headlined by the announcement that regents of the college had decided to continue the hospital standardization program, the American College of Surgeons 29th annual hospital conference here last month brought hospital people from throughout the country to discussions covering all phases of hospital operations as well as hospital-medical problems and relationships. The conference was held in connection with the college's annual clinical congress.

Dr. Paul R. Hawley, college director, was the principal speaker at the annual college convocation, where he stated that the only chance medicine had to win the battle against compulsory health insurance lay in "realization that profound social changes already have occurred which neither we nor anyone else can reverse."

Many medical men think present trends can be reversed, Dr. Hawley stated. "I am afraid this is wishful thinking; it is contrary to all experience with social revolutions. The best we can hope for is to halt the mad rush toward the welfare state; we can never backtrack. The time has come for us to catch up and adjust to the situation as it now exists."

Dr. A. P. Merrill, superintendent of St. Barnabas Hospital for Chronic Diseases, New York City, told the conference that hospital care of the aged and chronically ill in the United States today is a "national disgrace." Most of the victims of tuberculosis, arthritis, diabetes and conditions associated with arterio-sclerosis could be helped by modern medicine and new technics of rehabilitation, Dr. Merrill declared.

"No portion of our nation has been more neglected during sickness and dis-

(*Continued on Page* 136.)

Dr. MacEachern Retires From Active Service With College of Surgeons

CHICAGO.—Dr. Malcolm T. MacEachern has retired from active service with the American College of Surgeons, which he has served since 1923 as director of hospital activities, it was announced at college headquarters here last month. From 1935 to 1949, Dr. MacEachern was associate director and chairman of the administrative board of the college. In 1949 he was appointed director, and in March 1950 he became director emeritus, when Dr. Paul R. Hawley was named director. Dr. MacEachern will continue as professor and director of Northwestern University's course in hospital administration, and as chairman of the Tri-State Hospital Assembly, the announcement stated.

At the annual clinical congress of the American College of Surgeons at Boston last month, Dr. MacEachern was awarded an honorary fellowship. He is a past president of the American Hospital Association and the International Hospital Association, and in 1939 received the annual award of merit of the American Hospital Association.

Dr. Paul S. Ferguson who has assisted in administering the program since 1939 has been appointed to succeed Dr. MacEachern.

P.L. 725 Cutback Means Postponement of Projects, N.Y. Council Reports

NEW YORK.—The recent reduction in federal funds available for hospital construction will necessitate postponement of many worth-while projects, the Hospital Council of Greater New York announced here last month.

"The Hospital Survey and Construction Act places the highest priority on hospital construction and expansion in rural areas," the council said in its *Bulletin*. "Therefore it has been difficult to get adequate allotments for hospitals in New York City. When the act was amended last year to double the appropriations, it then seemed as if New York City had a real opportunity for undertaking some much needed projects. Therefore, the recent cutback in the amount of money appropriated for this year is of great concern to us and the people of this city."

The council had hoped to use a portion of the increased allotments for the construction of related facilities urgently needed in general hospitals, it was explained, including facilities for the care of ambulatory patients, units for tuberculosis, acute communicable diseases, convalescence and rehabilitation, chronic and mental diseases.

"Facilities for the care of ambulatory patients are extremely important in terms of value to the public, and valuable preventive work can also be accomplished in this department," the *Bulletin* stated. Outpatient services have shown a marked increase since the war, it was reported. The number of outpatient visits in voluntary and municipal hospitals has increased almost 30 per cent, the council said.

Shown above: Simmons Hospital Room No. 71. Color Scheme No. 7201 Dusty Rose with Shell. Self-Adjusting Bed, H-817-1-L-190: Dresser Base, F-180-3, with Mirror FM-62: Bedside Cabinets, F-480-F: Arm Chair, F-763: Chair, F-711: Footstool, F-909-R: Single Pedestal Overbed Table F-882.

This cleverly designed overbed table can be lowered to 29¾ inches for use by patient in chair. Maximum height of overbed table is 44¾ inches. Double hinged top permits use from either side of bed. Easily removed inset tray provides space for toilet articles, writing materials and other patient necessities. Order No. F-882.

Simmons skill works magic

—in Color, Comfort and Steel

There's magic in this new hospital room ensemble... in its soft, soothing colors to help restore health faster... in the way its mechanical features provide greater comfort and convenience for patients—less work for doctors and nurses. And there's magic in the way sturdy steel construction resists wear... defies fire!

The bed is Simmons famed Self-Adjusting Model that helps patients help themselves. The ingenious overbed table serves as table, book rest and vanity! The new Simfast finish in Dusty Rose with Shell resists damage from spilled liquids, medicine, heat and cold.

Here is beauty, convenience and long life to satisfy the most practical hospital administrator.

Metal furniture and sleep equipment for every hospital need.

Display Rooms: Chicago 54, Merchandise Mart Plaza
New York 16, One Park Avenue
Atlanta 1, 353 Jones Avenue, N. W.
San Francisco 11, 295 Bay Street

Simmons Company

Hospital Division

Write for new catalog of Simmons' complete line of hospital equipment.

NEWS...

Lueth Warns Nebraska Group of Impending Shortages of Personnel and Equipment

LINCOLN, NEB.—James G. Carr Jr. of Omaha was named president-elect of the Nebraska Hospital Association at the association's annual meeting here November 16 and 17. Mr. Carr is assistant administrator of the University of Nebraska Hospitals. Eugene J. Saxton of Dodge County Hospital, Fremont, succeeded Dr. Harold C. Lueth, dean of the University of Nebraska Medical School, and administrator of University Hospitals, as president of the association. Approximately 75 administrators from throughout the state attended the meeting, which was held in conjunction with conferences of the state associations of dietitians and medical record librarians.

In the opening address of the convention, Dr. Lueth warned that the nation's preparations for defense would mean shortages of equipment and supplies for hospitals, increasing difficulties in obtaining personnel and higher operating costs.

As the armed forces take more and more doctors, civilian doctors will have less time for home and office calls, with a consequent increasing burden on the hospital, Dr. Lueth said. He urged hospital people to study their procedures and technics closely in all departments to make certain that maximum results are being achieved with existing personnel. Increasing use of trained volunteers also offers a means of avoiding lowered standards of service if the personnel shortage looms, he added.

Robert Smith, assistant chief of the Omaha Bureau of Fire Prevention, and Walter Downey, an inspector on the bureau staff, presented a dramatic demonstration of fire hazards and fire extinguisher technics. Mr. Smith particularly urged constant emphasis on training employes to recognize fire hazards and take every possible fire safety precaution. Carelessness with equipment and housekeeping are the major causes of institutional fires, Mr. Smith said, and the only possible means of combating carelessness is rigid enforcement of housekeeping and fire safety rules. There is no substitute for fire drills, Mr. Smith declared, as a means of training employes in their duties when fire in the hospital is discovered. It is not necessary to involve patients in such drills, he added.

Notification to the hospital switchboard is the first duty of the person who discovers a hospital fire, Mr. Smith stated. The switchboard operator should know exactly what to do, first calling the city fire department, then notifying others in the hospital in carefully planned, and drilled, sequence. This should start the hospital's fire organization in action to protect patients in the area of the fire, to combat the fire itself with available extinguishing equipment, and to evacuate entirely whole areas or floors if necessary.

Mr. Smith said that the hospital's fire brigade should carry the responsibility for checking fire-fighting equipment systematically. He emphasized that the soda and acid type of extinguishers especially must be examined periodically to make certain they are in working order. He urged hospitals not to use fire extinguishers which do not have the Underwriters' approval label.

Mr. Downey demonstrated several types of fire extinguishers and explained the kinds of fires for which each is best suited.

Margaret Hill, director of the Interplan Service Benefit Bank of the Blue Cross Commission at Chicago, explained the operation of the bank and reported the volume of business now being conducted by Nebraska hospitals through the bank, which operates to provide Blue Cross members with full service in benefits in hospitals outside the areas served by their own Blue Cross plans.

In addition to Mr. Carr, other officers elected by the association were: vice president, T. J. McGinty, Lincoln; secretary, Paul Finnman; treasurer, Sister Mary Kevin; executive committee member, Reverend B. O. Lyle.

Discontinues Connection With Episcopal Diocese

PHILADELPHIA.—The Episcopal Hospital here has discontinued its connection with the Pennsylvania Diocese in order to qualify for state funds for care of indigent patients, it was reported here last month. The hospital has been an Episcopal institution for more than 100 years. Under Pennsylvania law sectarian hospitals are ineligible to accept state funds, it was explained. In order to qualify, the hospital has made changes in its constitution and by-laws which a local court has approved, making the institution nonsectarian.

1952 Administrators at Atlantic City Convention, A.H.A. Report Reveals

CHICAGO.—A total of 1952 administrators, representing 1611 hospitals in the United States, Canada and foreign countries attended the 1950 convention of the American Hospital Association in Atlantic City in September, the official registered report released by the association here last month indicated. The classification of administrator included assistant administrators, the report indicated.

Total registration at the convention was 7965, largest in the association's history, the report said. Of the total, 2100 were representatives of the 349 exhibiting firms and organizations, it was indicated.

In addition to administrators, other hospital representatives who attended the convention were 588 members of the women's auxiliary, 319 nurse anesthetists, 61 Blue Cross and other prepayment plan executives and 28 medical record librarians, the official count disclosed.

Affiliated groups in attendance were: architects (161), consultants (116), public health workers (87) and state plan agencies' representatives (49).

A final classification, "speakers and visitors," included 949 registrants, the report stated.

Maurice J. Norby, assistant director of the association, said copies of the complete registration list would be sent to exhibitors.

Student Nurses, Interns Are Not Included in Social Security Count

WASHINGTON, D.C.—Student nurses and interns are not to be included in counting employes to determine whether or not two-thirds are interested in having Social Security benefits, according to a regulation issued here last month in explanation of the revised Social Security Act making hospital employes eligible for benefits.

An earlier interpretation indicated that students and interns were to be counted in determining whether two-thirds of all employes wanted to be covered, even though such employes are excluded from benefits under the law.

The new regulation was published in the Federal Register for November 17, 1950.

NEWS...

Bruce Dickson Jr. Named President-Elect of Kansas Hospital Association

WICHITA, KAN.—Bruce W. Dickson Jr., administrator of Bethany Hospital at Kansas City, was named president-elect of the Kansas Hospital Association at the annual meeting here last month. Mr. Dickson will succeed Sister Rose Irene of St. Anthony Hospital, Sabetha, Kan., as president next year.

Approximately 300 people attended the meeting, largest convention ever held by the association.

Bishop Mark K. Carroll of Wichita was the principal speaker at the association's annual banquet where he reminded association members that the hospital's "soul" is revealed by a kindly, friendly attitude toward the sick and an understanding of the financial problems of patients and their families. "It will be most regrettable in our modern, business-like way of caring for paying patients if we should, through carelessness, indifference or greed, turn away any of the poor from a religious hospital," Bishop Carroll stated. "Like a human being, a hospital has both body and soul," the Bishop stated, "yet I have been in hospitals that were cold and cheerless, lacking the warmth that can be engendered only by charity and kindness."

The Kansas Fire Inspection Bureau stands ready to help hospitals with plans for addition, renovation or modernization, Ewing B. Fergus, a member of the bureau staff told the convention. Slight changes in plan often result in substantial savings on fire insurance premiums, Mr. Fergus stated. "To a large extent each hospital makes its own fire insurance rates," he declared. He suggested that an up-to-date appraisal always helps greatly in obtaining equitable adjustment following fire loss.

Speaking for the American Hospital Association, executive director George Bugbee said that restoration of the $75,000,000 cut-back in Hill-Burton funds might be possible. Legislation seeking to restore the fund to its former status will probably be instituted after Congress reconvenes, Mr. Bugbee reported. The association's Council on Government Relations has strongly recommended such legislation, he said. Speaking on the subject of hospital standardization, Mr. Bugbee said there was hope that a national commission, representative of the American Hospital Association, the American Medical Association, the American College of Surgeons and the American College of Physicians, might be set up. "A.H.A. trustees will insist on a satisfactory program," Mr. Bugbee stated, "and if other agencies cannot agree to such a program, the A.H.A. will go ahead on its own."

In addition to Mr. Dickson, other officers elected by the association were: vice president, Sister M. Aloysia, Pittsburg; secretary-treasurer, Carl C. Lamley, Topeka; trustees: Sister Mary George, Topeka; Henry J. Meiners, Leavenworth; Herman J. Andres, Newton; H. C. Jeppesen, Emporia; Charles B. Newell, Kansas City; DeLora E. Rodeen, Topeka. The executive secretary is Charles S. Billings.

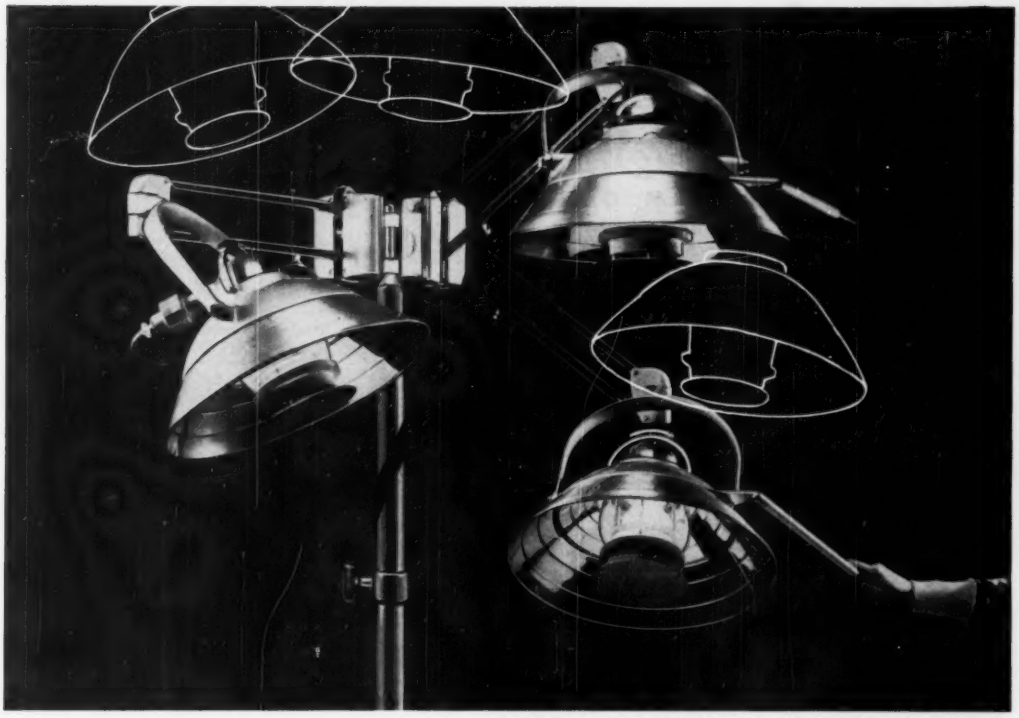
A.C.H.A. Fellows Seminar to Be Held in Chicago

CHICAGO. — An educational seminar for fellows of the American College of Hospital Administrators will be conducted at the University of Chicago December 13 to 16, Dean Conley, college director, announced here last month. The seminar will be led by members of the university faculty in political science, economics, anthropology, philosophy, sociology and administration. The purpose of the program will be "to clarify that which the hospital administrator should know about significant aspects of these fields and their ultimate effect on hospitals," the announcement said.

Similar programs have been conducted by the college for fellows in other sections of the country under the leadership of faculties from Columbia, Washington, Minnesota, Pittsburgh and Princeton universities, Mr. Conley said.

Open Cancer Hospital

PASADENA, CALIF. — A $1,000,000 cancer hospital will be opened at the City of Hope Medical Center at Duarte, Calif., some time in December, it was announced here last month. The hospital will provide accommodations for 100 cancer beds and bring the total capacity of the medical center to more than 400 beds. It was expected that patients would be admitted during the month of December, Victor M. Carter, president, said. In addition to providing facilities for care of bed patients, the hospital will provide an outpatient clinic for diagnostic service and clinical research, it was explained.



The Castle Explosion-Proof Safelight shown in a composite action photograph

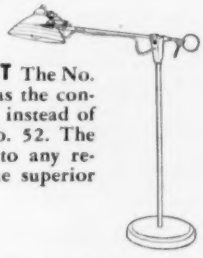
Why operating teams like this flexible, explosion-proof *Castle* Safelight

THE SURGEON BECAUSE: He gets the exceptional quality of light he expects and wants, just where he wants it, and *when* he wants it—*even when the nurse is not experienced.*

THE ASSISTANT BECAUSE: The novel optical system reduces shadow effects and *his helping* hands do not interfere with the surgeon's light.

THE SURGICAL NURSE BECAUSE: Quickly, as easily as pointing her finger, she can point the light just where the surgeon wants it. With universal focus the light is correct the instant she directs it.

THE ANAESTHETIST BECAUSE: He gets proper, color-corrected light for quick *perception of cyanosis.* He also knows that the Castle Safelight is explosion-proof and approved by the Underwriters' Laboratory for use in Class 1, Group C, Hazardous Locations.



CASTLE NO. 51 SAFELIGHT The No. 51 explosion-proof Safelight has the conventional counter-balanced arm instead of the pantograph arm on the No. 52. The lamphead raises, lowers, tilts to any required angle. It gives the same superior quality illumination.

EMERGENCY POWER UNITS AVAILABLE

Consult your dealer. For catalog write Wilmot Castle Co., 1271 University Ave., Rochester 7, N. Y

Castle **LIGHTS AND STERILIZERS**

NEWS...

Underwriters Board Lists Recommendations for Hospital Fire Safety

NEW YORK.—Correction of defective electric wiring, provision of automatic sprinkler production, organization of fire drills for personnel and provision of fire extinguishers were named among the most frequent recommendations for hospitals in a preliminary report last month by the National Board of Fire Underwriters, after tabulation of several hundred reports from the board's nationwide fire safety inspection of hospitals.

More than 4000 hospitals have been inspected in the survey, the board said, and seven states have reported completion of the statewide inspection program.

The states in which safety inspections are now finished were named as Arizona, Idaho, Indiana, Louisiana, Mississippi, Nevada and Utah.

In an effort to determine which fire hazards are most frequent the board tabulated inspection reports from 844 hospitals. In addition to the recommendations already named, other needs shown in the tabulation were compliance with Recommended Safe Practices for Hospital Operating Rooms, enclosure of stairways, provision of illuminated exit signs and emergency lights on separate circuits, removal of inflammable decorations, arrangements of exit doors to swing outward and provision of adequate first-aid installations.

Baptist Association Ends Relationship With Hospital

KANSAS CITY, MO.—The Kansas City Baptist Association, representing 45 churches in this area, has terminated its relationship with the Baptist Memorial Hospital here, it was announced last month. The hospital group is seeking to raise funds for a new institution to be constructed on a 23-acre site that has already been obtained, it was reported.

"Dissolution of the two groups was entirely friendly and cleared the atmosphere of unrest that has come since hospital trustees voted to accept federal aid in the hospital project," a statement released by the hospital group declared. "A number of church leaders feel that this move invaded constitutional provisions holding for a separation of church and state."

Because this can be 12 different doors

. . . it costs a lot less

One of 135 Fenestra Doors in Mandeville High School, Flint, Mich. Architect: Bennett & Straight of Dearborn. Contractor: Karl B. Foster, Flint.

The secret is a clever hinge arrangement—plus a muntin, a glass panel and a metal panel. This same beautiful Fenestra* Hollow Metal door can be used: Swing-in or swing-out . . . left or right hand—each with panels of metal or glass . . . with or without a muntin.

It costs a lot less because Fenestra craftsmen can give you the variety you need and still concentrate production facilities on a few basic high-quality types. Naturally, when production waste in time and money is eliminated, quality goes up and cost comes down.

This door is tough—it can be kicked and slammed and still look good. After years of use, a coat of paint will make it like new again.

This door is easy to handle—it swings open and shut smoothly, quietly. That operating balance never changes. Each door is packed with sound-smothering insulation.

This door is fire-safe—steel won't burn.

Door Comes Complete with Frame and Hardware. Each Fenestra door is carefully packaged to protect the gleaming finish. You can *count on* quality with Fenestra . . . over half a century a leader in metal fabrication. Take advantage of versatile Fenestra Stock Hollow Metal Doors. You'll appreciate their remarkably low cost. Call your Fenestra representative (listed in the yellow pages of your telephone directory) for further information, or . . .

*Trademark

Fenestra

Doors • Windows • Panels

MAIL THIS COUPON

DETROIT STEEL PRODUCTS COMPANY
Door Division
Dept. MH-12, 2258 E. Grand Boulevard
Detroit 11, Michigan

Please send me, without obligation, information on Fenestra Stock Hollow Metal Doors.

Name _____

Company _____

Address _____

NEWS...

Methods of Improving Medical Care Described at A.P.H.A. Convention

ST. LOUIS.—The greatest promise for improvement of medical care in the United States lies in regional organization of hospitals and in group practice, Dr. Franz Goldman of the Harvard School of Public Health declared in the annual meeting of the American Public Health Association here last month. "Freedom of experimentation with group practice is imperative in any country cherishing the free enterprise system," Dr. Goldman declared. "It must be developed together with full-time health units furnishing basic public health services, a well-rounded hospital system and a sufficient number of trained health personnel."

Dr. George Baehr, president of the Health Insurance Plan of Greater New York, described how group practice was combined with medical prepayment to meet familiar problems of medical care finances in the New York Health Insurance plan. These and other views expressed at the meeting were characterized by William H. Laurence of the *New York Times* as an "open challenge" to the American Medical Association. The A.M.A. was represented by Dr. Frank G. Dickinson, director of the Bureau of Economic Research, who said existing voluntary health insurance plans "should make it clear to everyone that voluntary insurance is now doing an excellent job."

Addressing the association on recent developments on Blue Cross and Blue Shield, E. A. vanSteenwyk, executive director of Blue Cross of Philadelphia, reported Blue Cross-Blue Shield progress and warned against the tendency to "toss the problem to an already burdened federal government." Mr. van Steenwyk urged support of legislation introduced in the last Congress by Sen. Lister Hill of Alabama aimed at providing federal funds for aid to indigents through existing voluntary prepayment plans. Mr. vanSteenwyk referred to recent national contracts for prepayment care in the steel industry as evidence that the voluntary programs were achieving integration on a national basis. Yet he assured the association that "the foundations of Blue Cross and Blue Shield are based upon local effort and personal responsibility. Though Blue Cross and Blue Shield recognize that their problems are in part national, the solutions to these problems will continue to be made locally. The dynamic character of their development as evidenced in the new national contracts, and in the inventive spirit of the community, plans everywhere will continue to meet the needs in the same forceful and commonsense way."

Capron Named President of Vermont Association

MONTPELIER, VT.—Charles W. Capron, administrator of Kerbs Memorial Hospital at St. Albans, was named president of the Vermont Hospital Association at the annual meeting here last month. Mr. Capron succeeds Gertrude Sharpe of Springfield Hospital, Springfield, Vt. Registration at the meeting was more than 135 hospital representatives including 50 members of women's auxiliaries throughout the state, making it the largest convention in the association's history.

Antone G. Singsen, assistant director of the Blue Cross Commission spoke on Blue Cross problems nationally and led a panel discussion in which hospital and Blue Cross representatives took part. Because of growing inflation and resulting economic pressures, the burden of hospital and medical costs is bearing heavily on Vermont cities and towns, W. Arthur Simpson declared in another address. Under these circumstances it is perhaps inevitable that there should be attempts to shift part of the burden from local to state funds, Mr. Simpson said. Yet he warned that even small increases would result in a huge burden on the state.

E. W. Jones, vice president of The Modern Hospital Publishing Co., Inc., addressed the convention on the subject of "Trustee Responsibility for Hospital Finances."

He suggested that hospitals might answer complaints about hospital bills by introducing itemized charges similar to those made in hotels so that patients would understand what services were involved in charges now grouped under a single heading.

In addition to Mr. Capron, officers named by the association were: vice president, Francis C. Houghton, Rutland Hospital; secretary, John R. Stone, Putnam Memorial Hospital in Bennington, and treasurer, Mary M. Ferry, superintendent, Heaton Hospital in Montpelier.

NEWS...

Dr. Hawley Addresses A.C.S. Congress

(*Continued From Page* 128.)

ease than the aged," he stated. "We lack 300,000 beds for the chronically ill now, not including those for TB and mental disease. It would cost more than 3 billion dollars to build them."

The shortage of trained professional personnel makes expansion of hospital facilities for mental disease under desirable minimum standards impossible today, Dr. M. A. Tarumianz, superintendent of Delaware State Hospital, told the conference. Mental hospitals have deteriorated owing to lack of trained personnel, modern physical facilities and funds, he stated. More than 5,000,000 adults are in need of outpatient psychiatric services, he added. To comply with approved minimum standards, hospitals would need to employ 900 psychiatrists, 3000 neurologists, 3000 clinical psychologists, 46,800 graduate nurses, 91,200 trained attendants and 25,000 additional technically trained workers, Dr. Tarumianz estimated.

In a clinical session of the college Dr. L. C. Roettig of Ohio State University described results obtained with Tryptar, a new drug that has been developed which has the power to dissolve dead tissue and other proteins in wounds and infections without affecting living tissue. Following Dr. Roettig's presentation, manufacturers of the drug announced inauguration of a research program aimed at clinical study of a number of different applications.

Dr. John N. Bowden, medical director of the United States Marine Hospital in Cleveland, stated that physicians and hospital attendants must take a more personal interest in patients. "We cannot be purely scientific in caring for a patient," Dr. Bowden stated. "As we become more specialized the patient as a person is left isolated on an island in the midst of a struggle to determine to which specialty he, as a case, should belong. We must learn to be personal with patients and other human beings."

Dr. Carl Walter, chief surgeon at Peter Bent Brigham Hospital here, described a new method of preserving blood which appears to extend the safe storage time. The method involves use of a special filter and chemicals, needles treated with a plastic substance which helps to preserve natural blood qualities.

Various sessions of the hospital standardization conference studied safe operating room practices, economic problems of voluntary hospitals, the coordination of medical and hospital services and hospital public relations.

Dr. Alton Ochsner of New Orleans was named president-elect.

A.M.A. Campaign Approved

BOSTON.—More than 70 per cent of the doctors in Massachusetts generally approve the publicity campaign through which the American Medical Association has been combating compulsory health insurance, a survey conducted by the *Boston Daily Globe* has revealed. Reported in the *Globe* last month, the survey covered 3500 Massachusetts doctors, of whom 71 per cent indicated approval when asked "Do you approve or disapprove the public information program which the American Medical Association is carrying out?" Twenty-four per cent of respondents disapproved the program, the *Globe* reported, and 5 per cent expressed no opinion.

NEWS...

Montana Convention Speaker Urges Hospitals to Recognize Responsibility for the Aged

MISSOULA, MONT.—Richard Lubben, administrator of Bozeman Deaconess Hospital, was reelected president of the Montana Hospital Association at the association's annual meeting here last month. Approximately 50 members of the association met for two days here and joined in several sessions with 150 members of the state nursing association, meeting concurrently.

In one of the principal addresses, presented to the hospital group, Walter A. Heath, administrator of the Tacoma General Hospital, Tacoma, Wash., and president of the Association of Western Hospitals, urged on community hospitals recognition of their responsibilities in connection with care of the aged. Mr. Heath said that an aging population made it imperative that facilities for the care of chronic illness and other infirmities common to old age be improved and expanded. No other agency except the general hospital is in a position to perform this function—one of the most important aspects of public health today, he declared.

Mr. Heath described the program for a special institute on problems of old age to be held at the Tacoma General Hospital under hospital sponsorship, designed to educate personnel of all interested agencies in the particular needs of the aged.

V. A. Burr, representing the Montana State Department of Public Welfare, spoke to the group about relationships between the hospital and county and state welfare agencies in connection with payment for the care of indigent patients. In a general discussion following Mr. Burr's presentation, officers of the association urged members to review rates of payment and negotiation with welfare officials looking toward establishment of an adequate return on these cases.

Harold K. Wright, administrator of Methodist Hospital at Sioux City, Iowa, and president of the Upper Mid-West Hospital Conference, reported details of the American Hospital Association convention at Atlantic City, and Harry Wheeler of Billings reported to the group on the convention last spring of the Upper Mid-West Hospital Association.

Richard Jones, director of the Blue Cross Commission, Chicago, spoke on national problems of Blue Cross and hospitals. He reviewed the development of Blue Cross as a national movement pointing out that hospital sponsorship and "partnership" in Blue Cross had been an essential factor of this development. Continued close cooperation between hospitals and Blue Cross plans will be essential to future success of the movement, he declared.

In addition to Mr. Lubben, other officers reelected for another term were: vice president, Robert Layng, St. Vincent's Hospital, Billings; secretary-treasurer, Edwin Grafton, Shodair Hospital, Helena.

Announce Dates for Institutes on Records, Personnel, Anesthetists

CHICAGO.—Institutes on medical records, personnel relations and anesthetists were announced for the forthcoming year by the American Hospital Association here last month. The institute for medical record library personnel will be held in Chicago January 22 to 26, the announcement said, and will cover the use and practice of standard nomenclature. The institute will be conducted jointly by the association and by the American Association of Medical Record Librarians.

The institute on personnel relations will be held at Santa Barbara, Calif., in cooperation with the California Institute of Technology January 29 to February 2. Technics of personnel management will be presented for hospital administrators and personnel executives, the announcement said.

The institute for nurse anesthetists is scheduled to be held at Jefferson-Hillman Hospital in Birmingham, Ala., February 19-23.

Union to Open Clinic

NEW YORK.—A new clinical building will soon be opened here by the Amalgamated Clothing Workers of America, it was announced last month. The union has purchased a residence building formerly operated by the Y.W.C.A. and is undertaking extensive alterations and remodeling to provide comprehensive health center facilities. The clinic will be known as the Sidney Hillman Foundation Health Center. Whinston & Whinston of New York are the architects.

TESTS PROVE.. POWERS

THERMOSTATIC SHOWER MIXERS
Give SAFEST Control Obtainable

ONLY ONE MOVING PART — Powerful thermostatic motor assembly is easily accessible from the front. *Simple* and *durable* construction insures long life and minimum of maintenance.

STANDARD TESTS

Federal Government Specifications (WW-P-541a) require that thermostatic water mixing valves be tested under conditions specified below:

Pressure Changes in Hot and Cold Water Supplies

50% Increase in pressure
50% Decrease in pressure
Failure of Cold or Hot Water Supply

Temperature Rise in Hot Water Supply

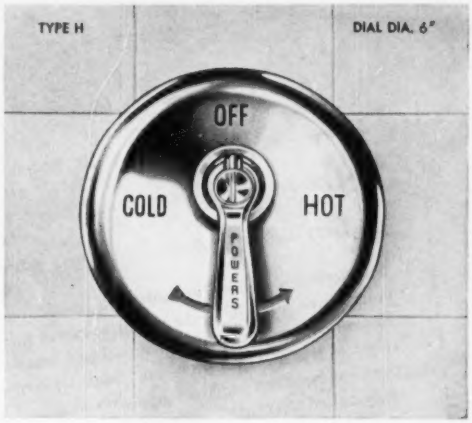
100° rise in temperature of hot water supply from 125 to 225°F

If You Test Various Water Mixing Valves by the above conditions . . . you will find that POWERS Type H THERMOSTATIC WATER MIXERS Will Out-perform All Other Mixers

Note that Government test specifications include TEMPERATURE rise. Pressure actuated mixers do not safeguard shower users against this danger.

"The BEST Showers

are regulated by POWERS"



● Proof obtained from tests described at left will show that no other *thermostatic* or *pressure actuated* shower mixer provides the greater safety insured by a Powers Type H Mixer.

In 1923 POWERS pioneered with the first pressure actuated type mixer which has been obsoleted by our far superior Type H Thermostatic Mixer. Its powerful quick acting thermostatic motor gives the most accurate control obtainable regardless of *pressure* or *temperature* changes in water supply lines.

When only one shower accident may cost many times more than POWERS mixers, why risk being "half-safe" with less than the safest mixer made?

(TM)

THE POWERS REGULATOR CO.
OFFICES IN OVER 50 CITIES • SEE YOUR PHONE BOOK
Over 58 Years of Water Temperature Control

CHICAGO 14, ILL., 2770 Greenview Ave. • NEW YORK 17, N.Y., 231 E. 46 St.
LOS ANGELES 5, CAL., 1808 W. 8th St. • TORONTO, ONT., 195 Spadina Ave.

NEWS...

California Nurses Ask Hospitals to Act Promptly on Social Security Program

LOS ANGELES. — A resolution asking California hospitals to act promptly to take advantage of the recently revised Social Security Act making old-age benefits and survivors' insurance available to hospital employes was adopted here last month at the 45th annual meeting of the California State Nurses' Association. In an effort to combat the shortages of nurses, the association created an associate membership at a reduced fee, designed to attract inactive nurses to membership and possibly to part-time employment in nursing.

The association also unanimously approved a resolution seeking to increase the salaries of general duty hospital nurses from $215 to $240 a month and adding $1 a day to the approved charge for private duty nursing service. The new private duty charge will be $12 for an eight hour day under the approved scale.

Gerda Hojer of Sweden, president of the International Council of Nurses, addressed the convention and described salary negotiations conducted by the Swedish Nurses' Association. "When negotiations between the association and employers bog down," Miss Hojer said, "nurses in affected institutions hand in their resignations, effective three months hence. Then negotiations continue, and in no case has it been necessary to carry out the threat of a walkout. This would be impossible in an association which did not include the majority of all graduate nurses in a community. There is great power in numbers, and it can be used to secure the things the nurses feel are justly theirs."

Miss Hojer reported that 95 per cent of all Swedish nurses belong to the association. Following her address, a San Diego paper headlined its release of a United Press dispatch from Los Angeles reporting the convention in this manner: "California Nurses Talk Mass Walkout." No such action was contemplated by the association, it was reported.

Dr. Elizabeth Porter, president of the American Nurses' Association, urged members to take active part in civic and political affairs and "to do their full duty as citizens." Miss Porter declared that nurses are part of the great group of educated women who have enjoyed the privileges of our country. "Now we must share the responsibilities of all

NEWS...

women of that group," she said. "We must not be content only with caring for the physical ills of the world. That is important, but it has many important sidelines."

35 per Cent Reduction in Use of Aluminum Ordered by Government

WASHINGTON, D.C.—A 35 per cent reduction in the use of aluminum for civilian purposes will become effective in January, according to an order issued here last month by the National Production Authority. William H. Harrison, N.P.A. administrator, said manufacturers would find ways to maintain their output of civilian goods by using aluminum substitutes or "stretching" obtainable supplies of aluminum.

Specifically, the order provided that civilian industries must not use more than 65 per cent of their average quarterly usage of aluminum during the first six months of 1950.

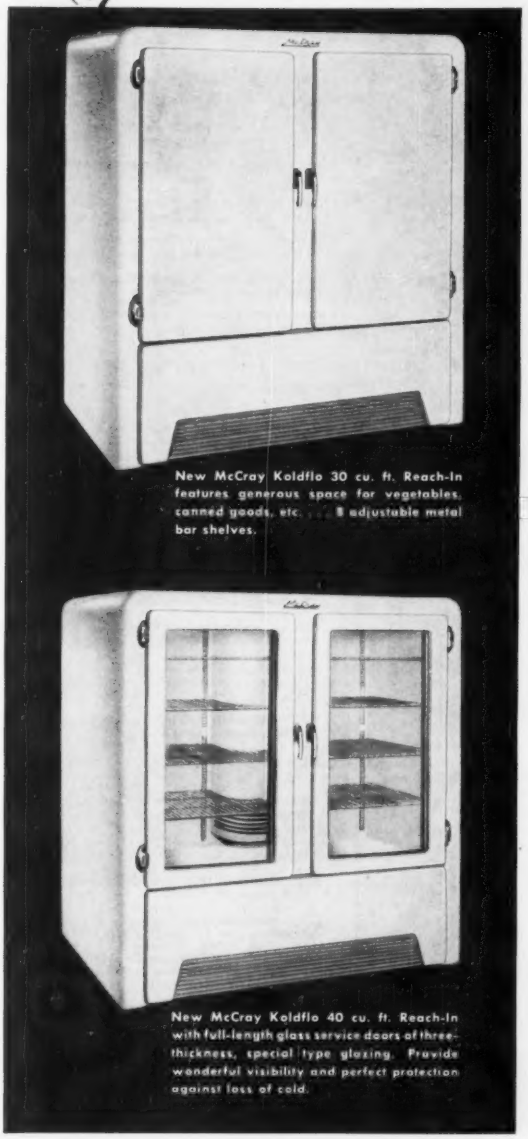
More than 30 per cent of the total available supply of aluminum was required for military production under presently authorized military programs, Administrator Harrison stated. He indicated that if larger military requirements than are presently contemplated should be approved by the Congress, an order banning all "nonessential" uses of aluminum might be necessary.

The administrator said one effect of the restriction would be to raise prices of aluminum products. Industries using less than 1000 pounds a year were exempt from the order, it was explained.

$3,500,000 Building Started at New England Deaconess Hospital in Boston

BOSTON.—Construction of a $3,500,000 building was undertaken last month at the New England Deaconess Hospital here. The new building will include operating suites and central supply and x-ray facilities, all fully air conditioned. The administration offices, the main lobby, flower and gift shops and other public rooms will be on the first floor. On the ground floor there will be a central kitchen, and a cafeteria for doctors, nurses, employes and visitors. When the new building is completed and alterations to the other buildings are effected, the Deaconess Hospital will have a net gain of 75 beds, bringing its capacity up to 375, a hospital official said.

...and there's more where this came from!



New McCray Koldflo 30 cu. ft. Reach-In features generous space for vegetables, canned goods, etc. . . . 8 adjustable metal bar shelves.

New McCray Koldflo 40 cu. ft. Reach-In with full-length glass service doors of three-thickness, special type glazing. Provide wonderful visibility and perfect protection against loss of cold.

● It's hard to explain . . . but on some days, everyone seems to go for a certain dessert on the menu.

If it's one that takes time to prepare . . . one that must be served immediately or else be refrigerated, you're faced with a problem found in every commercial kitchen.

The generous storage space *plus* the efficient operation of a McCray Koldflo Reach-In can make the difference between profit and loss for you. Here is refrigeration that prevents salads from wilting for hours before serving . . . that won't dry out pastries needing low temperatures . . . that keeps all perishables in perfect condition. The secret is controlled refrigeration—a perfect balance of temperature, humidity, and circulation.

It's famous McCray Koldflo "Up-from-Under" refrigeration—cold air that rises up to fill the entire storage area without blasting food surfaces.

Find out from your McCray dealer the many benefits in food preservation and kitchen organization that can be had with a McCray Koldflo Reach-In. Or write to the McCray Refrigerator Company, 1066 McCray Court, Kendallville, Indiana. (Distributors in principal cities—see telephone directory.)

A CHAMPION IN SERVICE
AN INVESTMENT IN QUALITY

McCray
KOLDFLO

COMMERCIAL REFRIGERATION
FOR EVERY NEED

NEWS...

COMING MEETINGS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, FELLOWS' SEMINAR, University of Chicago, Dec. 13-16.

1951

ALABAMA HOSPITAL ASSOCIATION, Hotel Thomas Jefferson, Birmingham, March 9, 10.

AMERICAN HOSPITAL ASSOCIATION MIDYEAR CONFERENCE, Drake Hotel, Chicago, Feb. 9, 10.

AMERICAN HOSPITAL ASSOCIATION, St. Louis, Sept. 17-20.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Congress Hotel, Chicago, March 1, 2.

ANNUAL CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS, Buena Vista Hotel, Biloxi, Miss., April 16-18.

ANNUAL CONGRESS ON MEDICAL EDUCATION AND LICENSURE, Palmer House, Chicago, Feb. 12, 13.

ARIZONA HOSPITAL ASSOCIATION, Adams Hotel, Phoenix, Feb. 16-17.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs National Park, May 15, 16.

ASSOCIATION OF METHODIST HOSPITALS, Congress Hotel, Chicago, Feb. 28.-March 1.

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 30-May 3.

CAROLINAS-VIRGINIA HOSPITAL CONFERENCE, Roanoke Hotel, Roanoke, Va., April 26, 27.

CATHOLIC HOSPITAL ASSOCIATION, Philadelphia, June 2-5.

FLORIDA HOSPITAL ASSOCIATION, Wyoming Hotel, Orlando, Dec. 4, 5.

GEORGIA HOSPITAL ASSOCIATION, Biltimore Hotel, Atlanta, Feb. 23, 24.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Nov. 29-Dec. 1.

INDIANA HOSPITAL ASSOCIATION, French Lick Springs Hotel, French Lick, May 23, 24.

INTERNATIONAL HOSPITAL FEDERATION, Brussels, July 15-21.

KENTUCKY HOSPITAL ASSOCIATION, Kentucky Hotel, Louisville, April 3-5.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, Jan. 26.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 23-25.

MIDWEST HOSPITAL ASSOCIATION, President Hotel and Municipal Auditorium, Kansas City, Mo., April 11-13.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 26-28.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 24.

NEW MEXICO HOSPITAL ASSOCIATION, La Fonda Hotel, Santa Fe, May 18, 19.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, April 2-5.

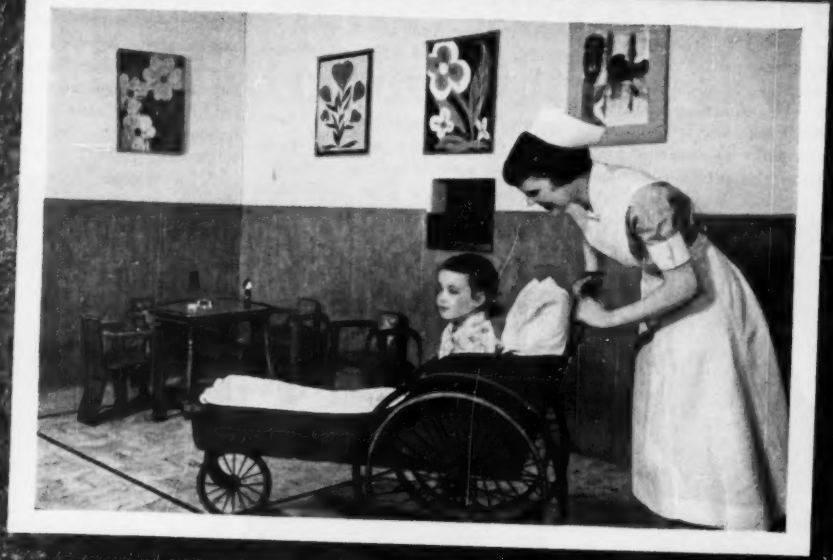
SOUTHEASTERN HOSPITAL CONFERENCE, Vinoy Park Hotel, St. Petersburg, Fla., April 4-6.

SOUTHWIDE BAPTIST HOSPITAL ASSOCIATION, COMMISSION OF BENEVOLENT INSTITUTIONS OF THE EVANGELICAL AND REFORMED CHURCH, ASSOCIATION OF EPISCOPAL HOSPITALS, Congress Hotel, Chicago, Feb. 28, March 1.

TENNESSEE HOSPITAL ASSOCIATION, Read House, Chattanooga, May 3-5.

TEXAS HOSPITAL ASSOCIATION, Municipal Auditorium, San Antonio, April 24-26.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 30-May 2.



Nursery of the Children's Hospital, Pittsburgh. Wainscoting of Pastel Green Kalistron. Architect—Percy Stevens. Contractor—F. Hoffman Co. Installation—General Interiors Corp., Pittsburgh.

WHY THESE COLORFUL WALLS

will **STAY** *colorful . . .*

Because these beautiful nursery walls are covered with Kalistron, they'll resist damage from spilled foods or liquids, from contact of rolling chairs or tables . . . *retain* their original glowing richness year after year. For exclusive Blanchardizing process fuses Kalistron color to *underside* of clear, extra-strength vinyl sheeting—thus color *can never show wear!* Suede-like backing adds further protection, permits easy bonding to wall surfaces.

Resistant to scratches, scuffs and spots, Kalistron won't chip, crack or peel. Waterproof, yet easily cleaned with a damp cloth. *Winner of Modern Plastics Award for furniture and interior decorating materials.*

Coupon below will bring sample of Kalistron plus top-quality nail-file . . . free. See if you can injure Kalistron even with this file.

Kalistron

PAT. APPLIED FOR

←COLOR FUSED TO UNDERSIDE

PLASTIC COVERING MATERIAL

U. S. Plywood Corp., Dept. F-38
55 West 44th St., New York 18

Please send me FREE Nail-File Test (swatch of Kalistron plus actual nail-file).

NAME _____

ADDRESS _____

_____

Distributed by: U. S. PLYWOOD CORPORATION, N. Y. C.
In Canada: PAUL COLLET & CO., LTD., MONTREAL

Color fused to underside of transparent vinyl sheet . . . backed by flocking

NEWS...

Fausey Named President-Elect at Annual Meeting of Michigan Association

DETROIT.—Glen W. Fausey, administrator of the Edward W. Sparrow Hospital at Lansing, was named president-elect of the Michigan Hospital Association at the 31st annual convention last month. Mr. Fausey will follow B. D. Dann of Muskegon, who succeeded Dr. E. Dwight Barnett as president during the convention here. Several hundred hospital administrators from throughout the state attended the three-day conference.

Addressing the annual banquet of the association, Dr. Charles F. Wilinsky, president of the American Hospital Association, described the conferences that were going forward to develop a workable standardization program for hospitals. No final agreement had been reached, Dr. Wilinsky said, and future conferences were scheduled; however, he indicated that a joint commission representing the American Hospital Association, the American College of Surgeons, the American College of Physicians and the American Medical Association might be established to conduct the standardization program.

E. Charlotte Waddell, for many years administrator of the Woman's Hospital, Detroit, was presented with a life membership in the association during the banquet program. Miss Waddell will retire next January, it was announced.

At a trustees' luncheon, Edwin J. Anderson, trustee of Children's Hospital, Detroit, urged administrators and trustees to take every possible step looking toward establishment of payment for indigent care on an adequate reimbursable cost formula. "City, county and state governments pay the established price for everything—automobiles, gasoline, coal and other commodities," Mr. Anderson declared, "Why should they pay less than cost for hospital care rendered in our voluntary institutions?"

At a round table discussion on administrative practice, several association members discussed various aspects of the hospital rate structure. Howard Wassenaar of Grand Rapids presented a simplified method of determining departmental and unit costs as a basis for establishing rates. With the assistance of a group of delegates attending the conference, Lauretta Paul, administrator of Pontiac General Hospital, led a dramatic presentation showing elements of the direct and indirect expense items in hospital cost accounting.

In another major convention address, Dr. Barnett and Harry Becker, welfare director of the United Automobile Workers union, discussed voluntary prepayment plans for hospital and medical care. Dr. Barnett warned that private commercial insurance companies could not meet the public demand for prepayment service. Such programs are a threat to the Blue Cross effort to extend voluntary prepayment to everybody who wants it, he said.

Mr. Becker emphasized that the commercial insurance companies have not developed hospitalization programs covering all the costs of comprehensive hospital service and were not concerned with higher standards of hospital care.

In addition to Mr. Fausey and Mr. Dann, other officers elected by the association were: first vice president, Sister Martina Murray; second vice president, Esther Morris; treasurer, Mildred Riese; trustees, William Klein, Sister Mary Theodosia and Ernest Forbes.

AGREED! COLGATE-PALMOLIVE-PEET TOILET SOAPS ARE REAL FAVORITES IN HOSPITALS!

SUPERINTENDENTS RECOGNIZE THE VALUE OF SOAPS THAT LEND PRESTIGE TO THE HOSPITAL'S PRIVATE ROOMS AND PAVILIONS!

PURCHASING AGENTS FIND COLGATE-PALMOLIVE-PEET SOAPS ECONOMICAL IN USE!

NURSES AGREE, TOO. PATIENTS LIKE TO FIND THEIR FAVORITE COLGATE-PALMOLIVE-PEET SOAPS!

All Three Agree on C. P. P.

PALMOLIVE—liked by everybody—meets the highest hospital standards in purity and mildness—a favorite with patients and nurses alike!

CASHMERE BOUQUET is a big favorite in private pavilions because women like the delicate perfume of this hard-milled pure luxury toilet soap.

COLGATE'S FLOATING SOAP is made especially for hospitals. For purity, mildness, economy, Colgate's Floating Soap meets the most rigid requirements.

FREE! New 1950 Handy Soap Buying Guide. Tells you the right soap for every purpose! See your C. P. P. representative, or write to our Industrial Department.

COLGATE-PALMOLIVE-PEET COMPANY

JERSEY CITY 2, N. J. • ATLANTA 3, GA. • CHICAGO 11, ILL. • KANSAS CITY 3, KANS. • BERKELEY 10, CALIF.

NEWS...

W. K. Kellogg Foundation to Finance Seminar on Nursing Administration

CHICAGO.—A five-month seminar on nursing service administration will begin next month at the University of Chicago under a $100,000 grant from the W. K. Kellogg Foundation, the university announced following a conference in which delegates from 12 major universities and a number of government and public health agencies participated. Herman Finer, professor of political science at the University of Chicago, is director of the project.

Two ranking nursing administrators or educators from each of the major universities, government health agencies and the armed forces nursing services will be invited to participate in the program of seminars and research, it was explained. "At present, there is not only a lack of well trained nursing administrators, but also a lack of well trained educators of nursing administrators," Prof. Finer said, reviewing findings of the preliminary conference.

"There is need to improve administration of nursing through all levels of professional and nonprofessional nursing services. The urgency is felt particularly with the rising standard of medical service the nation demands, the rapid application of new scientific discoveries, and the nation's mobilization for defense."

At the conference emphasis was placed on the necessity of educating top level administrators as a first step in the improvement of nursing administration generally. The problems to be solved include: determination of the best allocation of time between classroom instruction and in-service training, curriculum in nursing administration, the personnel required to teach nursing administration and to supervise in-service training, and the degree of democratic organization which can be obtained in nursing.

The seminar, Prof. Finer pointed out, will review these and other areas of administration — public, business and educational—to determine the best educational program for meeting administrative needs in nursing. The contribution of the various social sciences toward a better understanding of social relations in nursing will also be investigated, he explained.

Under the Kellogg Foundation grant, authorities in the administrative, medical and nursing fields will be invited to participate in seminar procedures; funds to defray the tuition and living expenses of persons attending the seminar from participating universities and government health agencies are also provided under the grant.

The Kellogg Foundation also indicated that it would consider financially aiding further development of programs of study in each university, as each implemented the seminar findings, the university announcement said.

Two Hospitals Announce Affiliation With U. of I. College of Medicine

CHICAGO. — An affiliation between St. Francis Hospital of Peoria and the University of Illinois College of Medicine has been established for the purpose of conducting a residency training program in surgery, the university announced here last month. Under the affiliation, qualified physicians who have received one or two years of surgical experience at the university's Research and Educational Hospitals in Chicago will be appointed to the St. Francis staff.

The plan will enable the university to train a larger number of qualified surgeons and to give them a more diversified teaching program, it was explained. In the three-year training program for resident surgeons, they will now receive instruction at a teaching institution as well as at a private community hospital.

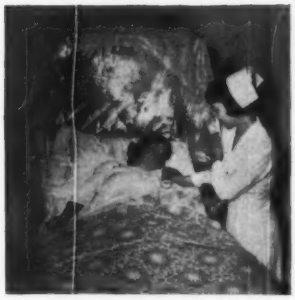
An affiliation has also been consummated between the university and Grant Hospital of Chicago, for the purpose of stimulating clinical teaching and organized research programs at both institutions. Announcement of the affiliation was made jointly by Hans S. Hansen, administrator of Grant, and Dr. A. C. Ivy, vice president of the university.

"The affiliation will give Grant Hospital a university connection and will enable it further to develop its teaching and research programs," the university stated. "Through its affiliation with a community hospital, the university will be able to expand its teaching facilities and will have available a private institution for the use of its professional staff members."

Under terms of the affiliation, all members of the present staff at Grant Hospital will continue in their present capacities. New appointments to the professional staff will be correlated by the university and the hospital.

Mr. Edward C. Dixon, President of Continental Hospital Service, Inc., presenting Visionaire canopies to Sister M. Aniceta, administrator of Braddock Hospital, Braddock, Pa. and to Mr. C. H. Pimlott, assistant director of University Hospitals, Cleveland, during the A.H.A. meeting at Atlantic City.

MORE THAN 1,000,000 CANOPIES SUPPLIED TO HOSPITALS by CONTINENTAL HOSPITAL SERVICE



The new Visionaire canopy is designed to completely fill every requirement of oxygen administration and bedside air conditioning with adequate facilities for nursing care.

Continental permanent-type canopies are manufactured to provide long life service. Their repeated use make for a low cost per patient attended.

AUTOMATIC, iceless oxygen tents are being used more and more for providing comfort to patients requiring oxygen therapy. Also, in many hospitals, individual bedside air conditioning is available to the patient thru the use of a Continentalair automatic oxygen tent.

As a result, the use of Visionaire canopies particularly, as well as the deluxe double weight and permanent type canopies has increased almost beyond imagination. On September 14, 1950, the Canopy Department of Continental Hospital Service, Inc. produced its one millionth canopy and started towards the second million during the regular day's production. To celebrate and mark this milestone in production a presentation from that day's production was made during the American Hospital Association Meeting at Atlantic City. Mr. Edward C. Dixon, the man behind Continental's progress in oxygen equipment and canopy manufacturing personally presented packages of Visionaire Canopies to Sister M. Aniceta of Braddock Hospital, Braddock, Pa. and C. H. Pimlott of University Hospitals of Cleveland.

The fact that hospitals have bought more than one million Continental made canopies in fourteen years time is abundant evidence of satisfaction to the buyer.

Visionaire Oxygen Tent Canopies are as transparent as fine glass. They are odorless and thereby eliminate disagreeable conditions to olfactory sensitive patients. Made of a *New* plastic that is stronger and more resistant to the effects of heavy oxygen concentrations. Their low cost justifies discard and disposal after each case as a safety measure against cross infection.

The new deluxe heavy-weight Visionaire Canopy is transparent and pliable. Elastic suspension tabs prevent tearing. Regularly furnished with folded service openings or at slight additional cost can be supplied with zipper openings at either or both sides. Can be washed with ordinary soap and water, and sterilized with any approved germicide for repeated use. When worn or torn can be converted into wet dressings, sheeting or patient throws.

The Continental designed permanent style canopy is made from a plasticized fabric. It is long wearing and withstands repeated cleansing and sterilization with all commonly used antiseptics. The large clearview windows permit good visibility.

Further details concerning the handling, servicing and stock maintenance of oxygen tent canopies can be obtained from Continental Hospital Service, Inc., 18636 Detroit Ave., Cleveland 7, Ohio.

NEWS...

Bugbee and Wilinsky Address Maryland-D.C.-Delaware Association

BALTIMORE. — Richard R. Griffith, director of the Delaware Hospital at Wilmington, was named president of the Maryland-District of Columbia-Delaware Hospital Association at the tenth anniversary conference of the association here last month. Mr. Griffith succeeded Leo Schmelzer, administrator of Garfield Memorial Hospital, Washington, D.C., retiring president.

General sessions of the conference featured presentations and discussions of major issues facing hospitals and the efforts of the American Hospital Association and its affiliated organizations to improve and extend patient care, and programs in the Maryland-District of Columbia-Delaware area to build and license hospitals and integrate medical services. George Bugbee, executive director, and Dr. Charles F. Wilinsky, president, described the American Hospital Association's projects.

The responsibilities of hospitals in the mobilization effort and civil defense were discussed at a luncheon meeting by Dr. John B. Pastore, of the Hospital Council of Greater New York.

Separate sections of the convention were devoted to discussion of current problems of purchasing agents, pharmacists, engineers, medical record librarians, accountants, housekeepers, dietitians, anesthetists and other departmental groups.

Laundry Management Course

PHILADELPHIA. — A course in laundry management began here last month under the sponsorship of the Community College and Technical Institute of Temple University. The course will teach principles of scientific laundry management in a series of two-hour evening sessions, lasting 40 weeks, the management service division of the institute announced.

The laundry management course was established in recognition of the constantly growing need for trained personnel in laundries, the announcement said. "This program is designed to develop in the class participant greater ability in managing a laundry operation efficiently and economically, and to provide him with the management skills necessary for cost reduction," it was explained.

St. Vincent's to Get 14 Stories

NEW YORK.—Plans for a 14 story addition to St. Vincent's Hospital here were revealed last month when Eggers & Higgins, hospital architects, filed the building plan with the city department of housing and buildings. The new addition will adjoin the Alfred E. Smith Memorial Building recently opened at the hospital.

ABOUT PEOPLE

(*Continued from Page* 80.)

Fred T. Eberhardt has been named administrator of the new Wing Memorial Hospital, Palmer, Mass. Mr. Eberhardt will take up his post there on December 10. He has resigned as purchasing agent of Manchester Memorial Hospital, Manchester, Conn., a position he held for the last four and one-half years.

Julius Gever has been appointed assistant superintendent of Philadelphia General Hospital, Philadelphia.

E. Charlotte Waddell, administrator of Woman's Hospital, Detroit, for more than 22 years, has announced that she will retire at the end of this year. Previous to going to Detroit, she was administrator of the Frances Willard Hospital, Chicago, from 1914 to 1928. All her preliminary education and professional training were received in Edinburgh, Scotland. Miss Waddell is an active member of the American and state hospital associations. She is a trustee of the Detroit Area Hospital Council, and a member of the American College of Hospital Administrators. For 17 consecutive years she was an elected member of the directors of the Detroit branch of the Michigan State Nurses' Association. She will retire to private life.

Sister Sebastian, formerly administrator and later president of the governing board of St. Agnes Hospital, Fond du Lac, Wis., has been named administrator of St. Anthony's Hospital, Hays, Kan.

Rev. Helmuth Buchmueller is the new superintendent of Evangelical Deaconess Hospital, Marshalltown, Iowa. The Rev. Buchmueller spent last year at the University of Chicago in the school of hospital administration.

Robert B. Jarvis has succeeded **Mrs. Edna Mae Eckert** as superintendent of Lock Haven Hospital, Lock Haven, Pa. Mr. Jarvis was formerly superintendent of Potter County Memorial Hospital, Coudersport, Pa.

Almena E. Wuerthner, R.N., has left her position as director of nurses at Jewish Hospital, Philadelphia, to become superintendent of Waynesboro Hospital, Waynesboro, Pa. She succeeded **Eleanor Faubel** at Waynesboro.

Department Heads

Dr. Frode Jensen has been appointed assistant dean, New York University Postgraduate Medical School, a unit of the New York University-Bellevue Medical Center. For the last three years Dr. Jensen has been director of the office of graduate and postgraduate medical education and associate professor of medicine at the University of Colorado School of Medicine.

Mrs. Emily K. Johnson has resigned as director of public relations at Rhode Island Hospital, Providence, and has accepted the position of director of public information with the Massachusetts Heart Association, Boston. Before joining the staff of Rhode Island Hospital in August 1948, Mrs. Johnson was public relations associate of the American Hospital Association.

Thaddeus A. Tryba is the director of the newly established public relations department at St. Mary of Nazareth Hospital, Chicago.

Miriam D. Rand has been appointed director of nursing service at Passavant Memorial Hospital, Chicago. Miss Rand also has been named director of the James Ward Thorne School of Nursing at Passavant Hospital and Northwestern University.

Mrs. George M. Kelly has been named pharmacist of the Presbyterian and Woman's hospitals, Pittsburgh. Her assistant is **Eileen Estep,** a graduate of the school of pharmacy of the University of Pittsburgh.

Robert F. Scates has been appointed purchasing agent of Baptist Memorial Hospital, Memphis, Tenn. Mr. Scates is a graduate of Baylor University and was formerly purchasing agent and editor of the *Triangle* at Southern Baptist Hospital, New Orleans.

Marian A. Euler, R.N., has been named director of nurses at Highland Park Hospital Foundation, Highland Park, Ill. She assumed her duties November 1, replacing **Mrs. Doris Moses, R.N.,** acting director, who has affiliated with civil service. Miss Euler was for three years director of nurses of the Central Michigan Community Hospital in Mount Pleasant. She is a graduate of the school of nursing, Warren Hospital in Phillipsburg, N.J., and has had postgraduate training in pediatrics, obstetrics,

Save Space, Save Steps, Save Money!

Serve Meals from STANLEY Bulk Containers

Temperature-hoarding STANLEY bulk food and drink containers, placed on serving carts, eliminate space-wasting kitchen pantries . . . save nurses and attendants hundreds of steps a day . . . get piping hot or frosty cold dishes and drinks to the patient's bedside efficiently and economically.

Genuine STANLEY thermal units are made of enduring, lightweight stainless steel, are completely crevice-free, easy-to-clean, and keep liquids or solid foods hot or cold for many hours.

Stainless Steel Food Jar. Keeps 8 individual casseroles or bulk foods, such as potatoes, vegetables, puddings, piping hot for hours. Available in 5 and 6.7 liquid quart sizes.

Stainless Steel Thermal Jar. Will hold either 6 individual casseroles or hot or cold bulk foods. Ideal as container for ice cubes, cold puddings, ice cream. Approximate capacity 5 liquid quarts.

Stainless Steel Beverage Jug. Has Quick Flow Spigot that comes apart for easy cleaning. Serves 8 ozs. coffee in 2½ seconds. 8 ozs. heaviest purees in 5 seconds. Available in 5 and 6.7 liquid quart sizes.

Genuine STANLEY
UNBREAKABLE THERMAL CONTAINERS

For information write . . .

STANLEY INSULATING DIVISION
LANDERS, FRARY & CLARK • NEW BRITAIN, CONN.

dietetics and x-ray, and special training in orthopedic nursing.

Miscellaneous

A. G. Stoughton

Alfred G. Stoughton, former chief of the office of hospital information, division of hospital facilities, U.S. Public Health Service, has joined the staff of the Washington service bureau of the American Hospital Association as assistant director. Mr. Stoughton was appointed to the division staff in 1946, at the time Public Law 725 was passed. Prior to this he had been a captain in the amphibian engineer command in the Southwest Pacific. A graduate of Bucknell University, Mr. Stoughton was alumni secretary and director of public relations at Bucknell for several years, then became director of public relations for the Young Men's Christian Association of New York City. He moved to Washington, D.C., to accept a similar position with the National Cathedral, and left the Cathedral post to enter military service.

E. E. Salisbury

J. R. Gersonde

Eugene E. Salisbury has been appointed executive vice president of the Association of California Hospitals, the association announced last month. For the last 10 years Mr. Salisbury has been executive director of the Chicago Hospital Council. He joined the council staff in 1937 as assistant director.

As vice president of the California association, Mr. Salisbury will be concerned with legislation affecting hospitals, with the association's public education program, and with the establishment of a reciprocal insurance company authorized recently by trustees of the association. His headquarters will be in San Francisco.

James R. Gersonde, who has been in charge of hospital relations for the Blue Cross Commission in Chicago, was named director of the Chicago Hospital Council, succeeding Mr. Salisbury. A graduate of the Northwestern University program in hospital administration, Mr. Gersonde served an administrative residency at Harper Hospital, Detroit, before going to the Blue Cross Commission.

Julia M. Miller has been appointed executive director, National League of Nursing Education. Miss Miller succeeds **Adelaide A. Mayo.**

Dr. Brian B. Blades, professor of surgery at George Washington University and chief consultant in thoracic surgery for the Veterans Administration, has been appointed to the administration's special medical advisory group. Dr. Blades' appointment was announced by **Dr. Paul B. Magnuson,** chief medical director of the V.A. department of medicine and surgery, who also announced the appointment of four other doctors to the board of chief consultants. They are: **Dr. Osborne A. Brines** of Detroit, professor of pathology at Wayne University; **Dr. Herbert L. Mantz** of Kansas City, tuberculosis controller of the Kansas City Health Department; **Dr. Walter O. Klingman,** associate professor of neurology at the University of Virginia, and **Dr. Donald A. Covalt,** clinical director and associate professor of rehabilitation of the New York University Institute of Rehabilitation and Physical Medicine.

for **MAXIMUM ASSURANCE OF SUCCESS**

IN TREATING ALL ASPHYXIATION CASES... ***it's***

E & J RESUSCITATORS

A large majority of the leading hospitals of the world have selected the automatic E&J Resuscitator because of its outstanding record of effectiveness in the treatment of advanced asphyxia ... its simplicity of operation ... its safety... its wide range of use throughout the hospital in treating adults, children and infants ... and its need in surgical and injury cases in which manual resuscitation is impractical.

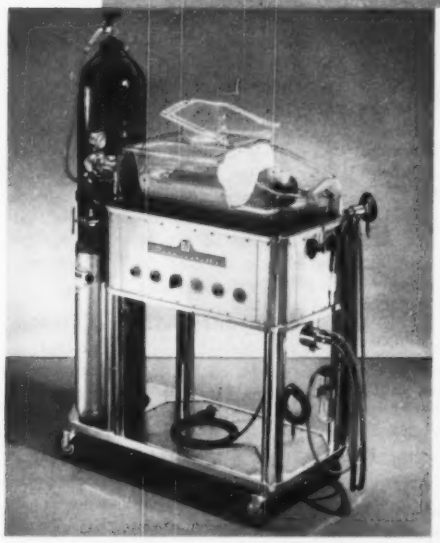
In every way the E&J is designed for complete dependability, utmost simplicity and the elimination of every possible chance of error in operation or in judgment, particularly in view of the tense circumstances under which it is usually used and the few moments available which make swift, assured action imperative.

IER STANDARD MODEL

IVR "LARGE TANK" MODEL

These two models have for years been the standard equipment of progressive hospitals throughout the world, contributing materially and often spectacularly to each hospital's never-ending fight to drive ever lower the ratio of patient deaths. Both models have the same operating mechanism and Controls. Both are accepted by the Council on Physical Medicine and Rehabilitation of the American Medical Association. **For complete information request Bulletin R503-2.**

The RESUSCINETTE *for the newborn*



For complete information request Bulletin R504-6

The Resuscinette has been developed by E&J engineers in co-operation with obstetricians to provide, for the first time and in *one* compact unit, *every facility needed for the logical sequence of treatment of the newborn!*

NOTE THESE FEATURES

1. **TRANSPARENT CRIB WITH 3-SECTION COVER** to receive the infant and hold in proper position for treatment.
2. **AUTOMATICALLY CONTROLLED WARM, MOIST ATMOSPHERE** within the crib to avoid shock of usual room temperature and humidity.
3. **FULLY ADJUSTABLE HEAD SUPPORT,** normally lowered, raised for cerebral hemorrhage cases.
4. **BUILT-IN E & J ASPIRATOR** at finger-tips for immediate clearance of air passages.
5. **BUILT-IN E & J POSITIVE-NEGATIVE RESUSCITATOR** with safe, gentle, fully controlled respiratory rate for resuscitation by either mask or intratracheal techniques, automatic signal if air passages are blocked and automatic signal when natural breathing starts.
6. **FULLY REGULATED OXYGEN ATMOSPHERE** in covered crib when natural breathing is established.
7. **COMPLETE PORTABILITY** so infant can be transferred to Nursery through corridors, in elevators, etc., *without disturbing temperature, humidity or oxygen atmosphere and without exposure or handling.*
8. **EMERGENCY USE AS INCUBATOR.**
9. **USE AS REGULAR RESUSCITATOR-ASPIRATOR** for routine treatment of *any person,* infant or adult.

Always glad to demonstrate!

E&J

E & J MANUFACTURING CO.
Glendale 1, California

NEWS...

Truman Committee Urges Chronic Disease Hospitals for Care of Veterans

WASHINGTON, D.C. — Establishment of "intermediary" hospitals to provide facilities for care of veterans with chronic diseases was recommended here last month by a special committee on veterans' hospital problems appointed by President Truman. The committee said such intermediary institutions would fill a "functional gap" between existing veterans' hospitals and domiciliary homes. The new hospitals would become an integral part of the V.A. service, according to the committee's plan.

Headed by Dr. Howard A. Rusk of New York University-Bellevue Medical Center, the committee included R./Adm. Robert L. Dennison and Dr. Arthur S. Abramson. The group was named last June following public protests over an order closing certain veterans' hospitals for further operation.

In addition to recommending the new type of hospitals, the committee approved the controversial cutback of 16,000 beds in the veterans' hospital construction program and observed that it will be "difficult if not impossible" to staff the 130,000 beds in the expanded V.A. hospital system.

The committee also urged Congress to give the Veterans Administration a definite policy to follow in connection with nonservice-connected disabilities. The current hospital system is adequate to provide facilities for all service-connected cases, the committee found.

Also recommended was a management survey of the medical service administration of the veterans program, which was described as "cumbersome."

Accountants Attend Clinic

CHICAGO.—A clinic on "late charges" was conducted by the American Association of Hospital Accountants here last month. Frederick T. Muncie of Chicago, program director for the Illinois chapter of the association, planned the presentation which was designed to "diagnose, prescribe and operate on problems concerning late charges."

The clinic was conducted in the auditorium of the Blue Cross Plan for Hospital Care office. A number of administrators from Chicago and down-state areas attended and presented their technics for preventing losses on "late charge" services.

Mr. Donald H. Clinton discusses the advantages of Dallas Ware, molded of Melmac plastic, which is used exclusively in both of his cafeterias.

"Use of your plastic dishes has saved us many thousands of dollars..."

—that's what this restaurant owner says about

dinnerware molded of MELMAC®

Ask the man who owns a restaurant!
For instance . . . Mr. Donald H. Clinton, owner and operator of the two highly successful Clifton Cafeterias in Los Angeles. He told us . . .

"The use of plastic dishes has saved us many thousands of dollars during the past two years; we now use them exclusively . . . serving some 20,000 daily."

"The lighter weight is also most desirable—both from customer and employee standpoint. We cannot sing the praises of Melmac Plastic Tableware too highly."

Yes, MELMAC-molded tableware is extremely low in rate of replacement. Clifton's, for instance, reduced its average replacement cost per meal to $.001624. Its breakage of china dishes had previously run as high as one hundred dozen per month!

Insist that your supplier give you *full* details on MELMAC plastic tableware—its beauty, durability, light weight, economy and ease of handling.

In Canada: North American Cyanamid Limited, Royal Bank Building, Toronto, Ontario, Canada.

AMERICAN Cyanamid COMPANY
PLASTICS DEPARTMENT
34D ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

NEWS...

Data on General Practice Revealed by Academy Survey

KANSAS CITY, MO.—General practitioners constitute half or more of the active staff of 90 per cent of hospitals under 50 beds in size, according to a survey conducted by the American Academy of General Practice. Results of the survey, which covered 375 hospitals, were reported here last month in *G.P.*, the academy's journal.

The number of general practitioners on the staff drops sharply as the size of the hospital increases, the survey revealed. Whereas 91 per cent of hospitals under 50 beds report that at least half the members of the active staff are in general practice, only 62 per cent of hospitals in the 50 to 100 bed group reported similarly. Among hospitals of 100 to 150 beds, 47 per cent indicated that half the active staff were in general practice; among hospitals of 150 beds or more, 19 per cent indicated that half or more of the staff were general practitioners.

The survey was made by questionnaires sent to hospitals with the academy's "Manual on the Establishment and Operation of a Department of General Practice in Hospitals." Commenting on the results, the journal pointed out that interpretation of the terms used in the survey might influence the results. "The questionnaire was sent out with the manual so the hospital administrator who returned the questionnaire promptly had not had an opportunity to acquaint himself with recommendations regarding privileges for general practitioners," the journal stated. "It is recommended that the information and data presented here be recognized as to their limitations and it should be understood that this survey is part of a program to develop a better understanding among hospitals and general practitioners as to the problems involved."

The survey showed that 60 per cent of hospitals having less than 50 beds had general practice departments. A somewhat smaller number of hospitals in the larger size groups reported organization of general practice departments.

Among all the hospitals, from 89 to 99 per cent, varying according to size, stated that general practitioners had equal opportunities with specialists in obtaining staff privileges.

"It is possible that there is considerable difference of opinion on the subject of equal opportunities," the journal observed. "In any case, more discussion at the hospital staff level on the relationship between specialists and general practitioners, and on the responsibilities and functions of all physicians in hospitals should prove to be an effective method of finding solutions to the particular problems of a given hospital."

Starts Technology School

CHICAGO.—A school of medical technology has been established at St. Mary of Nazareth Hospital here, Sister Mary Therese, hospital superintendent, announced last month. The new school is approved by the Council on Medical Education and Hospitals of the American Medical Association and offers a one-year course in bacteriology, biochemistry, serology, parasitology, hemotology and general chemistry to science students who have at least two years of previous college training. It will be under the direction of Dr. Eric W. Thurston, pathologist, and Sister Mary Wendeline, chief medical technologist.

NEWS...

Blue Cross Campaigns Against Excessive Use of Hospital Service

CHICAGO. — A campaign to combat excessive use of hospital services provided under Blue Cross contracts was undertaken by the Blue Cross Plan for Hospital Care here last month. The opening step of the campaign was a news letter to physicians asking doctors to cooperate in holding Blue Cross charges down.

Explaining that it had been necessary to raise membership rates because of increasing use of hospitals by Blue Cross members, the letter, which was signed by the professional relations committee for Blue Cross-Blue Shield of the Chicago Medical Society, said the plans desired to give "all the members the care they need when they need it." But Blue Cross "simply cannot pay for any unnecessary days of hospital care or other type of service not eligible for benefits," the committee declared.

"You as a physician can be of assistance," the message urged, "for you are the sole judge of what your patients need. By being certain no member receives hospital service benefits unless actually entitled to them, you can help keep Blue Cross charges down." The committee also sought cooperation of physicians in explaining to their patients the necessity for raising Blue Cross-Blue Shield membership rates.

"The growth of Blue Cross membership and service is becoming an increasingly important factor in the health and welfare of the communities which it serves," the message concluded. "Every member who receives unnecessary benefits in the long run forces rates upward, and excessive rates strengthen the argument for socialized medicine. May we continue to count on your friendly support and cooperation?"

N.Y. Hospitals Given Details of Civil Defense Program

NEW YORK. — Voluntary, city and proprietary hospitals here have been given details of an organized plan outlining their part in the civil defense program, Dr. Marcus D. Kogel, commissioner of hospitals, announced last month. Hospital planning is under the direction of a hospital facilities section of the civil defense organization, it was explained.

Dr. Alexander W. Kruger of the municipal hospitals staff, and Dr. Marta Fraenkel, director of the Department of Medical Statistics and Records Service, were named chief and assistant chief respectively of the hospital section.

Members of the regional committees under Dr. Kruger and Dr. Fraenkel were named, representing hospitals in each of the five boroughs.

Mary Ellen Manley, director of nursing education and service of the Department of Hospitals, was named chief of the nursing services section of the organization.

Wyoming Elects Reifel

CHEYENNE, WYO. — Leo W. Reifel, administrator of Ivinson Memorial Hospital, Laramie, was elected president of the Wyoming Hospital Association for 1951 at the association's annual meeting held here last month. Ernst H. Stewart, district manager of the Worland Hospital, was named vice president, and Fred H. Ware of Laramie County Memorial Hospital at Cheyenne was elected secretary-treasurer.

for long range economy . . . .

POLAR WARE

Stainless Steel

Clinical Utensils

The trend today is toward stainless steel clinical utensils—and particularly the kind that Polar Ware makes. There are many good reasons why this is true, but none more important than the improved measure of sterility provided by the seamless construction that identifies Polar Ware craftsmanship in metal working. . . . . And when you consider that the same fabricating methods that make these well designed utensils so easy to work with also make them almost indestructible, you can understand why Polar Ware has earned a reputation for providing the most for your money in terms of long range economy.

Leading hospital supply houses everywhere carry Polar Ware. Ask the men who call on you, or if you prefer, write direct for information on the *complete* Polar Ware line.

Polar Ware Co. 2121 LAKE SHORE ROAD SHEBOYGAN, WISCONSIN

NEWS...

New Device Relieves Respiratory Obstruction in New-Born Infants

CHICAGO.—An inexpensive device to relieve respiratory obstruction in newborn infants was described in the October 21 issue of the *Journal of the American Medical Association*. The device is simple and inexpensive and can be made in the laboratory, it was reported by Ernest B. Emerson Jr., of the University of Rochester School of Medicine, Rochester, N.Y.

The instrument consists of a ureteral catheter with a cylinder tip, multiple openings at the side and an oblique open end, which is inserted into the throat. The catheter is attached to a suction device consisting of a rubber hose and bulb; operation of the bulb removes obstructing material, such as blood, mucus and foreign particles from the respiratory tract, Dr. Emerson said.

Reporting on using the device in 79 cases of breathing difficulty, Dr. Emerson described the results as "entirely successful" in every case in which the respiratory distress was due to obstruction by foreign materials, such as mucus and blood.

Three Hospitals Plan Jewish Medical Center

PHILADELPHIA.—Mount Sinai, Northern Liberties and Jewish Hospitals here have approved an agreement to merge their facilities as an initial step toward establishment of a major medical center for the Jewish community here, the *Bulletin* of the Pennsylvania Hospital Association reported last month. Plans call for later inclusion of four other institutions: Philadelphia Psychiatric Hospital, Eagleville Sanatorium, Community Health Center and Willow Crest Convalescent Home, it was explained.

Hospitals Lose $4.15 per Day on Indigents, A.H.A. Reports

CHICAGO.—General hospitals are losing an average of $4.15 a patient day on care of indigent patients paid for by city, county and state agencies, according to a hospital rate survey published here last month by the American Hospital Association. The survey indicated that general hospitals received an average of $8.73 a day from government agencies as reimbursement for care of such patients. Payments based on the government reimbursable cost formula average $12.88 per day, the survey disclosed, or $4.15 less than actual payments. This amounted to 32 per cent of the reimbursable cost figure.

Laundry Managers Meet

BOSTON.—Oscar Ketchum of Hondo, Calif., was elected president of the National Association of Institutional Laundry Managers at the annual meeting here last month. The conference was devoted to discussions of technical interest to laundry managers in hospitals and other institutions, personnel management problems, methods of dealing with growing shortages of skilled and unskilled labor, and laundry accounting and record-keeping. Other officers elected by the association were: first vice president, Arthur F. Hornickel; second vice president, John F. Felker; treasurer, Frank Lippman, and secretary, Donalda Smith.

Now—Carolina presents

CAROLINA-MAID

A New Line of Hospital Apparel Sturdily-Made for Long, Hard Wear

COST-CONSCIOUS hospital executives will approve the many quality features of Carolina-Maid apparel—features which give longer service and help to reduce repair time and cost.

Quality comes first in Carolina-Maid apparel, starting with the specially-selected fabric. Then, every construction detail is designed for long, comfortable service. Every stress point is bar-tacked. All joining seams are two-needle seams, locked and bolted down. Each yoke is put through two extra sewing operations to insure strength and permanance. Tie tapes are put in so solidly that the fabric will give first. Even the hems are tough, turned over and double sewn. Literally, Carolina-Maid apparel will not fall apart at the seams.

Comfort, too, is provided. Carolina-Maid apparel is generously cut and sizes run full, giving ample room for easy action. A trial of Carolina-Maid apparel will convince you that maximum wearability and resistance to hospital laundering is built into these garments. Send for the new illustrated catalog and prices today.

Send for this catalog today

CAROLINA ABSORBENT COTTON CO.

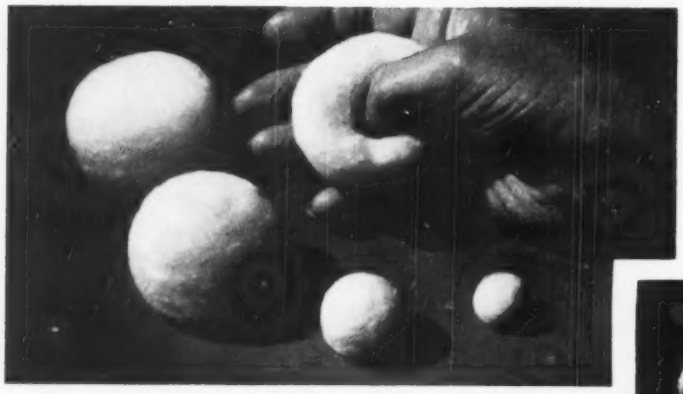
(Division of Barnhardt Mfg. Co.)

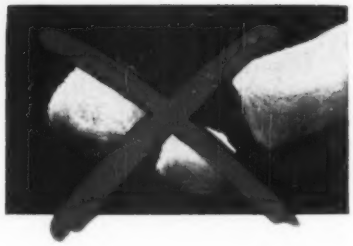
CHARLOTTE, N.C.

Carolab Hospital Supplies

QUALITY PRODUCTS OF COTTON SINCE 1900

WHY leading Hospitals are using CAROLINA COTTON BALLS!





Efficiency and cost are most important when you select cotton balls for your hospital.

"Home-made" cotton balls are variable in size. They have tag ends which wipe off on the wound or surface. They waste cotton, and their cost must include material *and* labor.

Carolina Cotton Balls are uniform and compact, not wispy and loose. Made of finely spun selected long staple cotton, they are highly absorbent—and are free of nibs. Their construction makes a firm, yet very resilient ball which holds its spherical shape. Ready for use after sterilizing, these cotton balls save you money.

Carolina Cotton Balls are supplied in five sizes, each for a particular need, whether it's the small size for E.N.T. work or the super or special sizes for vaginal cleansing. Available:

Super	**2000 per case**
Special	**2000 per case**
Large	**2000 per case**
Medium	**4000 per case**
Small	**8000 per case**

CAROLINA ABSORBENT COTTON CO.

(Division of Barnhardt Mfg. Co.)

CHARLOTTE, N.C.

Other Carolina Products

Sanitary Napkins

Combination pads and rolls

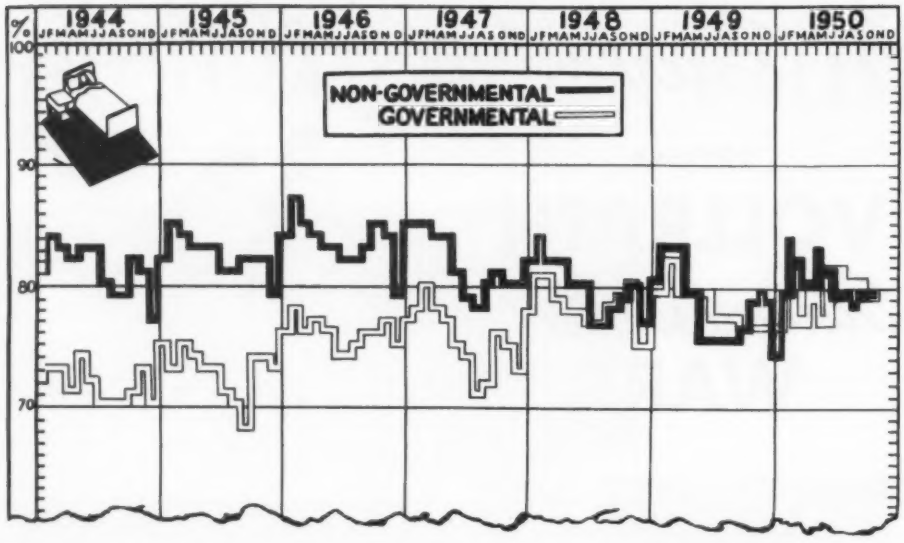
Absorbent cotton

Carolab Hospital Supplies

HIA Hospital Industries Association

MANUFACTURED WHERE GROWN

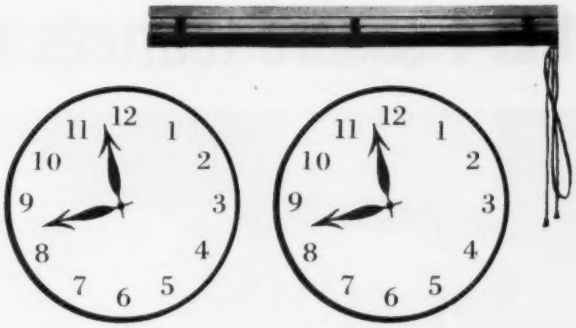
Hospital Occupancy Increases Slightly



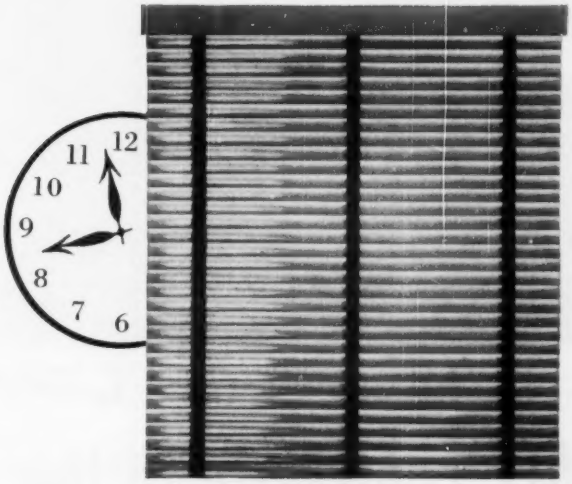
At 80.1 per cent of capacity, occupancy of voluntary hospitals reporting to the Occupancy Chart for the month of October was slightly higher than it was in September, and a little ahead of the same month in 1949. Governmental hospitals reported 80.3 per cent occupancy for October—also a slight increase over October 1949.

Hospital construction reported for the October-November period totaled $55,693,448, bringing the total for the year to $775,418,759. This was 62 per cent greater than the total at the same date last year. Of projects reported for the latest period, 15 were new hospitals costing $18,729,000 and 32 were additions totaling $29,293,000.

cleaning time cut from hours



to minutes



with

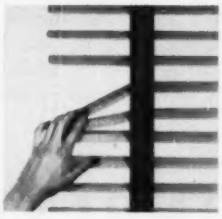
new *Flexalum* plastic tape

and spring-tempered aluminum slats

Guaranteed by Good Housekeeping

NEW PLASTIC TAPE WIPES CLEAN!

That's the maintenance secret! No hours wasted scrubbing: a damp cloth does the job perfectly in seconds! No money wasted replacing worn-out tapes, either: Flexalum tape keeps its looks in spite of weather and wear, won't fade, shrink, stretch, fray, or mildew. The one tape that belongs at business windows is Flexalum—the tape that's built to stand abuse!



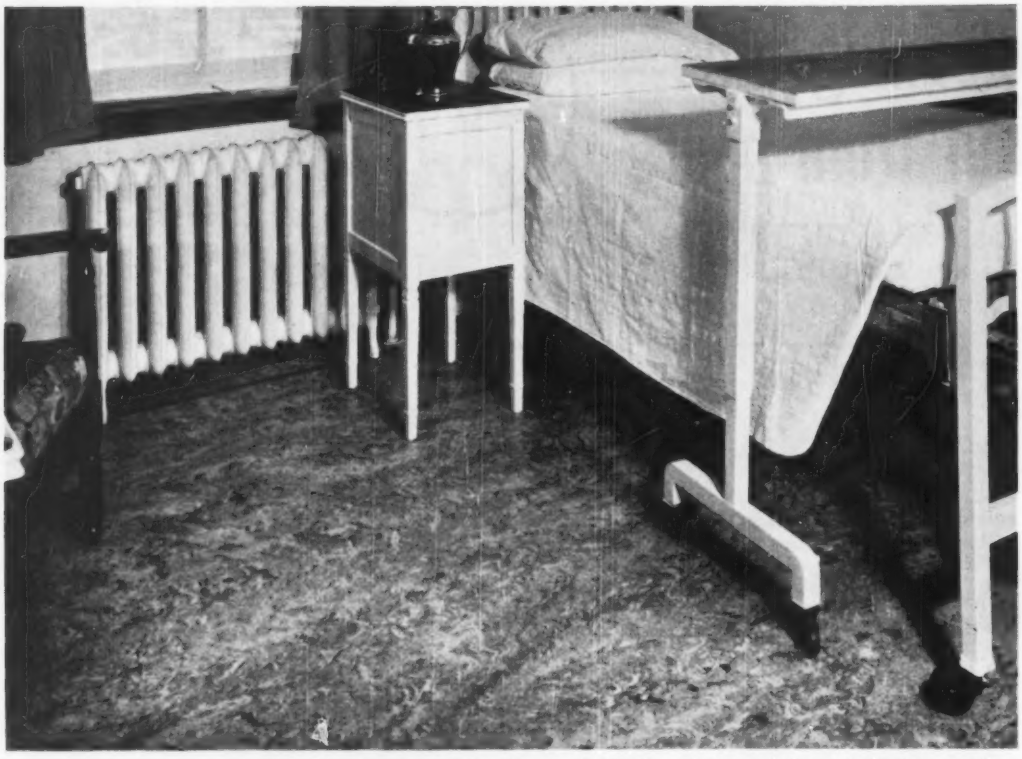
SNAP-BACK SLATS—ANOTHER FLEXALUM EXCLUSIVE!

Supple aluminum slats spring-tempered by a process exclusive with Hunter Douglas—the only slats that snap back to perfect shape when bent to a 90° angle at the route hole! Baked-on finish won't chip, crack, peel, rust; sheds dirt quickly. Maintenance and repair costs slashed to minimum! Only Flexalum slats with the visible-invisible trademark can offer you all these features.

Write for maintenance booklet See Flexalum Specifications in Sweet's File Architectural Section $\frac{19e}{Hu}$ Builder's File $\frac{3g}{Hu}$

HUNTER DOUGLAS CORPORATION, RIVERSIDE, CALIF. AND 150 BROADWAY, NEW YORK 7, N. Y.

the 4-square features of Nairn Linoleum



Nairn Linoleum makes this floor in the Hackensack General Hospital, Hackensack, New Jersey, quiet and foot-easy . . . satin-smooth surface eliminates dirt- and germ-catching crevices.

ALL contribute to this hospital's floor!

Yes, the vital combination of long life, enduring beauty, easy maintenance, and true resilience make this Nairn Linoleum floor a wise choice for *any hospital!*

Many a Nairn floor has given 20 years, or more of the heaviest service. Its quiet beauty is a constant joy. While its smooth, sanitary surface—free from germ-breeding cracks—makes it easy to keep immaculate. Clatter and the noise of foot-traffic are hushed, thanks to the unusual resiliency of Nairn Linoleum. It's without question a most economical floor covering in the long, trouble-free service required of any hospital floor covering!

1. Long Life
2. Enduring Beauty
3. Easy Maintenance
4. True Resilience

NAIRN LINOLEUM for Floors and Walls

Trademark ®

For your requirements:
Nairn Linoleum
Nairn Wall Linoleum
Nairn Asphalt Tile
Congoleum-Nairn Inc.,
Kearny, New Jersey

F.O.B. BUFFALO...
540 *Guaranteed*
YEARS OF SERVICE!

EACH Life-Long "12" carries the HARD-bound guarantee of 12 years of trouble-free service. Thus—our recent shipment of 45 Life-Long "12" Mattresses to the Franklin County Hospital actually represented 540 years of complete satisfaction.

In recent months—166 hospital administrators have realized that in today's rising market only Life-Long "12" offers them definite economy. Their *initial cost* is their *last cost* — and, for about a penny a day, their mattress problem is solved for the next 12 years at least !

Hard's tradition of fine craftsmenship and 74 years in the manufacture of all important hospital furniture makes this GUARANTEED SERVICE PLAN possible.

Long term assurance will be yours too, when you replace your old mattresses with the new Life-Long "12".

Available in all sizes to fit standard and Trendelenberg gatch springs.

Permalator Insulation between tempered spring-wire "hour-glass" coils.

Inner-roll construction gives permanence of shape and firmness of perimeter.

Eye-let Ventilated Breathing - Border . . . Fine quality 8 - ounce Tick Covering. . . .

HARD MANUFACTURING CO.
BUFFALO 7, NEW YORK
FOUNDED 1876

Order from your selected Hard Surgical Supply Dealer.
Write for Catalog Page . . . Dept. MH 12

New High in Hospital Efficiency

the world's finest

LOUD-SPEAKING NURSES' CALL SYSTEMS

Compact bed-side speaker operates at pleasant, low, non-annoying level.

At the master station, nurse learns patient's needs without wasting steps and time.

EDWARDS, with its 78-years' experience in precision-engineered signal equipment — and Stromberg-Carlson, with its acknowledged leadership in audio products, bring you a truly modern hospital communication system.

Edwards Loud-Speaking Nurses' Call System provides complete foolproof signaling . . . instant communication between patient and nurse with greater convenience and efficiency. Master Nurses' Station keyboard includes highgrade telephone type, cam lever switches, 3-level volume control and press-to-talk switch. Amplifier is easily accessible and replaceable—thus avoiding costly service charges. Note these other important features:

Complete privacy is assured. Only nurse at master station can receive patient's spoken message and this is received through telephone handset.

Double safety factor provided . . . both visual and audible signals continuously operate should plug accidentally come out or become partly dislodged. Convenient . . . easy re-set feature.

Locking push-button has luminous cap — an added convenience to patient. Eliminates groping in darkened rooms.

Exclusive, patented security clamp constantly keeps calling button within patient's reach . . . clips on bedside table or pillow.

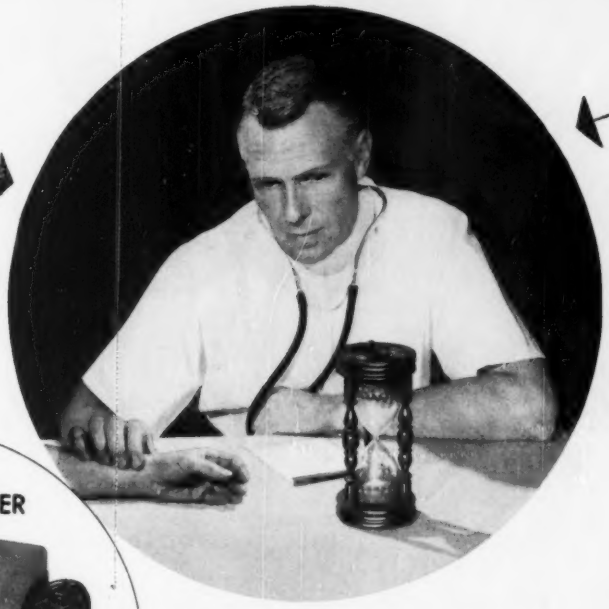
Super-sensitive speaker with over-size amplifier provides high-fidelity reception. Precision designed into a compact bedside flush wall unit which fits standard gang boxes. Speaker mounts behind attractive stainless steel face plate either alone or ganged with locking push, pilot light, radio-jacks or duplex receptacles.

Hospital tested design assures reliable trouble-free service.

EDWARDS *Company Inc.*

NORWALK, CONN. *In Canada: Edwards of Canada, Ltd.*

Ridiculous? Why, of course, Doctor!



Dictation is EASIER

with AUDOGRAPH

Yet, methods of medical record-keeping no less archaic are still accepted in practice . . . depriving physicians, surgeons, hospital staffs of *time*.

AUDOGRAPH has done something about this . . . has indicated the way to streamline your professional day by practically eliminating *handwritten* notes of observations, diagnoses, findings and post-surgical reports.

With AUDOGRAPH at your elbow, Doctor, you may *record* the vital facts conveniently . . . and with an economy of *time* and *money* that will be a welcome change from the old way of putting pertinent data in black and white.

To free yourself for other essentials of your practice . . . to acquaint yourself with the full story of AUDOGRAPH's capacity to streamline *your* medical record-keeping . . . mail the coupon, *today!* You will be in no manner obligated, and the consequent benefits may surprise you.

Made by The Gray Manufacturing Company—established in 1891—originators of the Telephone Pay Station.

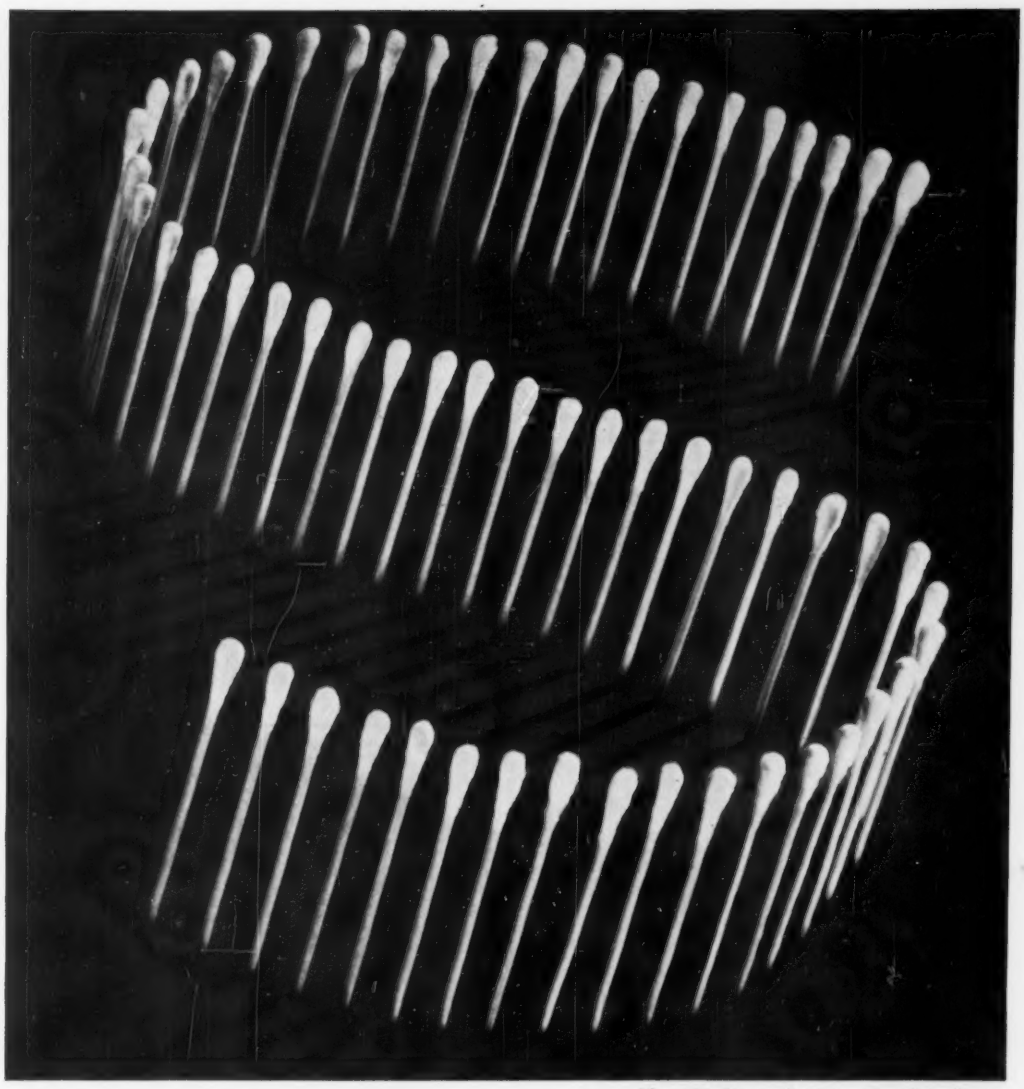
The "Master" Audograph: the ideal combination dictating and transcribing machine. Records on thin, lightweight, long-lasting plastic discs holding up to *one hour's dictation*. Will operate wherever electric current is available.

Gray
AUDOGRAPH
ELECTRONIC SOUNDWRITER

AUDOGRAPH sales and service in 180 principal cities of the U.S. See your Classified Telephone Directory—under "Dictating Machines." Canada: Northern Electric Company, Ltd., sole authorized agents for the Dominion. Overseas: Westrex Corporation (export affiliate of Western Electric Export Company) in thirty-five foreign countries.

TRADE MARK AUDOGRAPH REG. U. S. PAT. OFF.

- THE GRAY MANUFACTURING COMPANY, HARTFORD 1, CONNECTICUT
- Send me Booklet P-12—"Saving The Doctor's Time."
- Name .....
- Street .....
- City ..... State .....



Glasco Machine-made Cotton-Tipped Applicators

YOU'LL NEVER GO BACK TO HAND WRAPPING

Once you have tried Glasco Machine-made Cotton-Tipped Applicators, you will never go back to time-wasting, costly hand wrapping.

For Glasco Cotton-Tipped Applicators will cost you less than the wood stick, the cotton, the labor—and the time—of assembling old-style applicators.

Too, Glasco Cotton-Tipped Applicators are uniform, clean, tightly wrapped and come to you in sanitary envelopes with 100 in each so that applicators may be kept at every convenient spot.

Save time, labor and money. Use the more sanitary, uniform and effective Glasco Cotton-Tipped Applicators.

Consult your Glasco Catalog, or ask your hospital supply salesman about lengths and size of wraps. Or write Glasco Products Company, 111 North Canal Street, Chicago 6, Illinois.

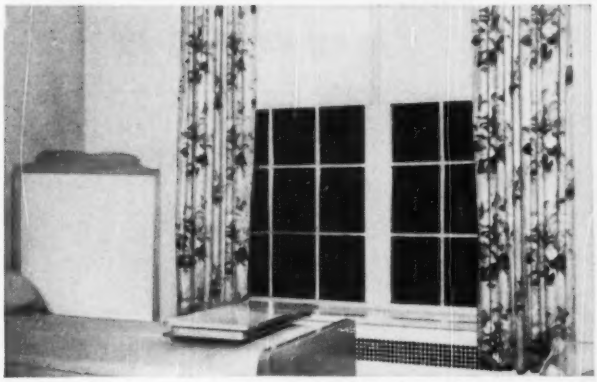
GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

For Beauty and Economy

The New Alfred E. Smith Memorial Wing of St. Vincent's Hospital decorates with

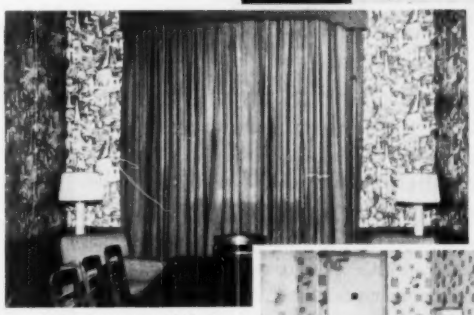
Goodall



Three floors of modern, private rooms reflect the comfort, luxury, and good taste that's achieved with harmonizing Goodall fabrics.

The new Alfred E. Smith Memorial wing at West 12th Street in New York City.

St. Vincent's kept their beauty standards high, long range costs low, by using Goodall fabrics in this distinguished Board of Directors' room. →



Interesting textures in Goodall fabrics carry out the modern theme of the new wing in the administrative offices.

GOODALL DRAPERIES
GOODALL UPHOLSTERY
GOODALL CUBICLES
GOODALL CASEMENTS
GOODALL BEDSPREADS

Easy-to-clean Goodall fabrics are the ideal choice to brighten the visitor's waiting room.

RELIGIOUS and public officials saw the latest in hospital equipment and appointments when St. Vincent's proudly opened its Alfred E. Smith Memorial wing on May 14, 1950. Goodall fabrics were in evidence everywhere, creating an atmosphere of beauty, comfort, and good cheer. These fabrics are *Blended-for-Performance* with enriching angora mohair and other choice fibers. Naturally, they combine the economy of longer wear and easier maintenance with their famous beauty. The new wing of St. Vincent's is just one of the many modern hospitals benefiting from Goodall fabrics. They can be seen wherever far-sighted administrators are decorating for today and tomorrow.

Goodall-Fabrics
THE FINEST NAME IN FABRICS

A Dream Come True!

We proudly salute the leaders and friends of the Geisinger Memorial Hospital and Clinic at Danville, Pa., whose hard work and generosity raised a million dollars for the magnificent new Foss Clinic, dedicated November 4, 1950. The total authorized cost of the project was $1,412,326, including a government grant.

This building, the tangible result of a fund-raising campaign directed by this firm in 1948, is named for Dr. Harold L. Foss, Surgeon-in-Chief and Chief of Staff of the Hospital.

The brick and glass and steel shown above assure Central Pennsylvania of a

superbly equipped, modern diagnostic clinic. And they represent the culmination of the dreams and the perseverance of a progressive community.

KETCHUM, INC.

Campaign Direction

CHAMBER OF COMMERCE BLDG., PITTSBURGH 19, PENNSYLVANIA

CARLTON G. KETCHUM, *President* — NORMAN MACLEOD, *Exec. Vice President* — MCCLEAN WORK, *Vice President*

500 FIFTH AVENUE, NEW YORK 18, NEW YORK

H. L. GILES, *Eastern Manager*

MEMBER AMERICAN ASSOCIATION OF FUND RAISING COUNSEL

There are two beautiful sides to this door story

Architects Ferrenz & Taylor take advantage of the great versatility of Weldwood Stay-Strate Doors

These Weldwood Stay-Strate doors in the Fitkin Memorial Hospital, Asbury Park, N. J., combine birch faces on one side with walnut faces on the other. The addition of walnut moldings was all that was necessary to give a traditional paneled effect.

Here's one place where it pays to be two-faced.

The Weldwood® Stay-Strate Doors (with Kaylo* Core) in the Board Room of the Fitkin Memorial Hospital, in Asbury Park, New Jersey, are a beautiful example of how you can blend these versatile doors with almost any decorative scheme.

One side has the sheer, flush face that goes with the decorative motif of the entrance hall. The other, using walnut molding, has a paneled effect that blends perfectly with the traditional setting of the interior.

And . . . on top of decorative versatility . . . this modern door has many other advantages to offer.

The Weldwood Stay-Strate Door won't warp – in fact, a strong guarantee to this effect appears on every door. Here's a door that stays straight – that won't shrink or swell – not only when it's installed, but throughout its entire life!

Because it's constructed with the same incombustible mineral core material used in the famous Weldwood Fire Door . . . you get unusually effective fire protection. Use it in unclassified openings as the perfect complement to the Weldwood Fire Door.

In addition, the Weldwood Kaylo Core Door can be specified where you need:

Maximum Dimensional Stability . . .
Light Weight . . .
Extraordinary Durability . . .
Waterproof Bond . . .
Suitable for both interior and exterior use . . .

Specify lights and/or louvers to your needs, and we'll cut them before shipment. Face veneers can be had in a wide variety of domestic and imported hardwoods.

. . .

United States Plywood Corporation carries the most complete line of flush doors on the market including the famous Weldwood Fire Doors, Weldwood Stay-Strate Doors, Weldwood Honeycomb Doors, Mengel Hollow-core Doors, Mengel and Algoma Lumber Core Doors, 1⅜" and 1¾" with a variety of both foreign and domestic face veneers.

*T. M. Reg. U. S. Pat. Off., Owens-Illinois Glass Co.

ANOTHER WELDWOOD DOOR . . .
the famous WELDWOOD FIRE DOOR with THE UNDERWRITERS' LABEL . . .

gives you complete fire protection at moderate cost.

Here's your opportunity to combine protection *and* decoration in one beautifully finished, moderately priced, *wood-faced* flush door.

This door carries the Underwriters' Label for Class "B" openings, and can be so used with complete assurance of approval for fireproof construction.

Available in a wide range of sizes . . . up to 4 ft. wide and 7 ft. high . . . and in a variety of imported and domestic hardwoods . . . the Weldwood Fire Door has recently received Underwriters' approval to carry light openings up to 10 in. square.

Weldwood®

WELDWOOD Flush Doors

Manufactured and distributed by

UNITED STATES PLYWOOD CORPORATION

55 West 44th Street, New York 18, N. Y.

Branches in Principal Cities • Distributing Units in Chief Trading Areas • Dealers Everywhere

Architect's model of the University Section of the New York University-Bellevue Medical Center.

Mission in Progress

Now under construction is the new University Section of the New York University-Bellevue Medical Center. Two medical schools, 19 hospitals and more than 1,000 doctors and scientists are affiliated with this great project – an enterprise dedicated to bringing better health to more people.

This great adventure in health envisions a medical center which with its affiliated hospitals will have a total capacity of 4,500 beds available for care of the sick, teaching and research.

The Utica-Mohawk Cotton Mills are proud that their sheets are used by the New York University Hospital – proud that their sheets live up to the high standards of an institution that has such a mission in progress.

UTICA SHEETS

WOVEN EXTRA STRONG . . . TO WEAR EXTRA LONG

UTICA MOHAWK

UTICA AND MOHAWK COTTON MILLS, INC., Utica 1, New York • Selling Agents: Taylor, Pinkham & Co., Inc. 55 Worth Street, New York 13, N. Y. • 300 West Adams Street, Chicago 6, Ill. • 605 Market St., San Francisco 11, Cal.

Want Advertisements

POSITIONS WANTED

ADMINISTRATOR—Assistant; 7 years' hospital experience, 13 years' business experience, including legal, investment counsel, real estate, insurance and hospital; thorough knowledge all phases business office procedure; established record credits, collections and public relations; college girl, 34 years old, single; free to change location. MW 24, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Nurse; AANA member; experienced in use of all gases; Pentothal Sodium and Curare; prefer east or mid-west. MW 18, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LIBRARIAN—Medical record; registered; graduate approved school; B.S. Degree; eleven years' experience; thorough knowledge standard nomenclature; desires position preferably in New England, but would consider others. MW 23, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

DIRECTOR OF NURSING EDUCATION—M.A. Degree, Columbia University; 6 years' director, collegiate school of nursing, western university; 2 years', 300-bed hospital; New York state.

ADMINISTRATOR — B.B.A., Degree, 1949; graduate large Michigan hospital; experience, 2 years' business manager, large private clinic; 9 years', superintendent, 80-bed general hospital.

ADMINISTRATOR—Graduate eastern university; 1 year course, hospital administration. 10 years' experience, public accountant; past 12 years, purchasing agent, assistant administrator and director, 200-300 bed eastern hospitals.

EXECUTIVE HOUSEKEEPER — Degree in Home Economics; 7 years' charge of housekeeping 400-bed hospital, large Pennsylvania hospital; any locality considered.

DIRECTOR, NURSING SERVICE—Or assistant; B.S. Degree, New York University; 3 years' ward instructor; 5 years' nursing arts instructor; past 4 years' assistant director, nursing service; desires placement in east or southeast.

DIRECTOR OF NURSING—Or assistant superintendent; B.S. Degree, University of Southern California; 15 years' successful experience as nurse executive, eastern and western hospital; 6 years' director of nursing, 500-bed hospital; available.

ADMINISTRATOR—Degree, Hospital Administration, Northwestern University; 3 years' assistant administrator, 200-bed Illinois hospital, where extensive building program was carried on; ability above average.

BUSINESS MANAGER—4 years' University of Pennsylvania; 3 years' purchasing agent, 250-bed Maryland hospital; 3 years' administrator, 100-bed private hospital.

THE MEDICAL BUREAU

Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATOR—Medical; five years, assistant administrator, voluntary hospital, 500 beds; eight years, director, university hospital, 600 beds; six years, on faculty, university school of Hospital Administration; FACHA.

ADMINISTRATOR—M.B.A., Hospital Administration, year's administrative residency and three years, assistant administrator, large teaching hospital; five years, director, 200-bed hospital, unit university group.

ADMINISTRATOR—M.S., Hospital Administration; accounting background, CPA, year's administrative residency; two years' administrative assistantship, large hospital.

ANESTHESIOLOGIST—Training in anesthesiology, large teaching hospital; four years, anesthesiologist, 250-bed hospital.

ADMINISTRATOR — Graduate nurse, several years' supervising experience; Master's Degree, Hospital Administration; year's residency in hospital administration, teaching hospital; two years, administrator, small hospital.

DIRECTOR OF NURSES—M.A., Columbia; graduate of university school of nursing; five years' experience as instructor and educational director; four years, assistant dean, university school; past several years, director of nurses, 250-bed hospital.

MEDICAL DIRECTOR—Tuberculosis specialist; degrees, leading schools; since 1940, medical director, 175-bed sanatorium.

PATHOLOGIST — Of outstanding qualifications; B.M., M.D., M.Sc., Ph.D., one of leading universities; four years, assistant professor of pathology; six years, professor and head department pathology, university medical school and director of pathology; 350-bed hospital; Diplomate; F.C.A.P.

RADIOLOGIST—Diplomate American Board; Fellow American College of Radiology; seven years, director, radiology, 300-bed hospital; past six years, radiologist, group limiting practice to radiology; prefers directorship of hospital department.

WOODWARD MEDICAL PERSONNEL BUREAU

(Formerly Aznoe's)

Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ADMINISTRATOR — FACHA; Early forties; excellent training and experience in all phases of large hospital administration; experience includes 3 years', assistant, state hospital program; 4 years', administrator, 400-bed southern hospital; 4 years', administrator, 500-bed important general voluntary hospital; active in local and national hospital affairs; interested in hospitals 300 beds up; immediately available.

WOODWARD—*Continued*

ADMINISTRATOR—Member, ACHA; early forties; B.S., M.S. Hospital Administration; well trained accountant; experience includes 1 year, business manager, 250-bed general hospital; past 3 years', administrator 100-bed southern hospital; immediately available.

ADMINISTRATOR—M.Sc., Ph. D.; middle forties; experience includes 2 years,' manager, 110-bed general hospital; past year, administrator, 150-bed hospital; available 30 days.

ADMINISTRATOR—B.A., M.S. Hospital Administration; early thirties; 3 years' administration officer, United States Army 1000-1500-bed hospitals; year's administrative hospital residency; past year, administrative assistant, 300-bed general hospital; immediately available.

ADMINISTRATOR — Medical; FACHA; has taken leading and responsible part in local and national hospital affairs; experience includes administrator, 9 years, large southern teaching hospital; early forties; immediately available.

CERTIFIED RADIOLOGIST—34; training includes year teaching fellowship, pathology; 2½ years', residency in radiology; past year, chief, roentgenologist, 400-bed eastern hospital; DNB; immediately available.

CERTIFIED PATHOLOGIST—34; training includes excellent 4 year residency, pathology; past year, pathologist and director of laboratory, 1400-bed university hospital; immediately available.

CERTIFIED PATHOLOGIST—Early thirties; surgical internship; experience includes 3 years', medical technologist; past 5 years', instructor in pathology, university medical school; only mid-west localities; available several months.

CERTIFIED ANESTHESIOLOGIST — Early thirties; experience includes several years' United States Army hospitals as chief, departments of anesthesiology; 1 year, anesthesiologist, southern university hospital; past 3 years', associate in private practice of anesthesiology; immediately available.

NURSE ANESTHETIST—Registered; 35; experience includes 6 years', teaching anesthesia, large midwest teaching hospital; past 18 months', chief anesthetist, 1000-bed university hospital; consider only chief positions; immediately available; $450.

X-RAY TECHNICIAN—Male; 34; 3 years', private laboratory practice of x-ray and physiotherapy; several years', charge of x-ray, United States Army; 2 years', chief x-ray technician, 250-bed general hospital; past 2 years', chief of x-ray, large eastern general hospital; knowledge of chemistry; immediately available.

REGISTERED MEDICAL RECORD LIBRARIAN—35; single; experience includes 4 years', MRL; 450-bed general hospital; 3 years', MRL, 350-bed general hospital; available 2 months.

HOUSEKEEPER—College trained; widow; 50; experience includes 6 years', executive housekeeper several large hospitals up to 450 beds; past 2 years', executive housekeeper, large midwest general hospital; 2 months notice.

Terms: 20c a word—minimum charge of $4.00 regardless of discounts. No charge for "key" number. Ten per cent discount for two or more insertions without changes of copy. Forms close 15th of month.

(Continued on page 180)

Want Advertisements

POSITIONS OPEN

ADMINISTRATIVE—Assistant; nursing service; 500-bed hospital; Bachelor's Degree and experience; 5-day week. MO 5, The Modern Hospital, 919 N. Michigan Ave, Chicago 11.

ANESTHETIST—Nurse; for 100-bed general hospital in northeastern Minnesota; two anesthetists employed; $350 and maintenance. Apply John M. Alexon, Administrator, Municipal Hospital, Virginia, Minnesota.

ANESTHETIST—Registered nurse; small modern hospital; college town; excellent salary, plus full maintenance; unusually good working conditions. Apply Administrator, Centre County Hospital, Bellefonte, Pennsylvania.

ANESTHETIST—Nurse; for 300-bed hospital; four anesthetists now on service; salary open. Apply, D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

ANESTHETIST—For 40-bed hospital located in a city of 4500, only 80 miles south of Chicago; good transportation to Chicago; good salary, two weeks vacation, ten days sick leave, meals and laundry furnished. Send full particulars when applying to Administrator, Iroquois Hospital, Watseka, Illinois.

ANESTHETIST—Registered nurse; for 75-bed A.H.A. and A.C.S. approved hospital; salary and working conditions among the best. Apply Director, Harford Memorial Hospital, Havre de Grace, Maryland.

ANESTHETIST—Registered nurse; for 45-bed general hospital; salary open; paid vacation; sick leave; overtime pay. Administrator, Douglas Community Hospital, Inc., Roseburg, Oregon.

ANESTHETISTS—Nurse, 175-bed general hospital, near Chicago; salary $300 with maintenance; $350 without maintenance. MO 91, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETISTS—Nurse anesthetists; two urgently needed; modern, well equipped, 100-bed hospital, employing only graduate staff; attractive location within forty minutes of San Francisco; five day week; excellent salary; maintenance available. Administrator, Alameda Hospital, Alameda, California.

DIETITIAN—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

DIETITIAN—ADA; small modern hospital; college town; excellent salary, plus full maintenance; good working conditions. Apply Administrator, Centre County Hospital, Bellefonte, Pennsylvania.

DIETITIAN—Therapeutic; 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIAN—For 100-bed hospital; salary depends on experience and qualifications; for particulars apply Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick.

(Continued on page 182)

DIRECTOR—Educational; for progressive 100-bed general hospital with 50 student nurses; attractive personnel policies; salary open, depending upon experience and qualifications; maintenance. For further information write, Director of Nursing, Lutheran Hospital, Vicksburg, Mississippi.

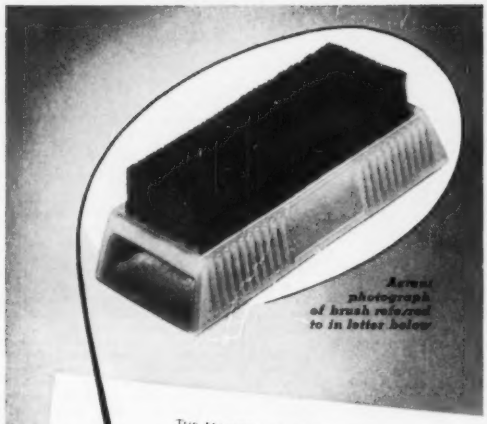
EDUCATIONAL DIRECTOR—Position open August 1; 285-bed hospital, 125 students; salary open, depending on experience and qualifications; living in nurses' residence optional; paid vacations and sick leave. Apply Director of Nurses, Mercy Hospital School of Nursing, 806 Cleveland Avenue, N.W., Canton 2, Ohio.

INSTRUCTOR—Clinical; with degree for approved school of nursing; 200-bed general hospital; desirable working and living conditions; attractive personnel policy; salary open, with or without maintenance; excellent opportunity to continue with university work. Apply, Director, School of Nursing, Franklin Square Hospital, Baltimore 23, Maryland.

INSTRUCTOR—Operating room nursing; 500-bed hospital; Bachelor's Degree; 40-hour week. MO 3, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR—Clinical; medical-surgical nursing; Bachelor's Degree; school connected with 475-bed hospital; 5-day week. MO 4, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTORS—Clinical; 2; medical and surgical for 325-bed general hospital; degree and experience preferred. Apply, Director, School of Nursing, The Toledo Hospital, Toledo, Ohio.



THE MEMORIAL HOSPITAL
AT EASTON, MD., INC.

ANCHOR BRUSH COMPANY, 8/30/49
AURORA, ILL.

GENTLEMEN –

WE ARE PLEASED TO WRITE IN REFERENCE TO THE ENCLOSED "ANCHOR NYLON SURGEON'S BRUSH". THIS BRUSH HAS BEEN IN CONSTANT USE SINCE APRIL, 1948, BEING AUTOCLAVED AT LEAST ONCE DAILY. AS YOU WILL SEE THE BRISTLES HAVE MAINTAINED THEIR FIRMNESS AND NONE HAVE BECOME LOOSE OR BROKEN OFF. WE CONSIDER IT A VERY ECONOMICAL PURCHASE AT WHAT FIRST APPEARS TO BE A HIGH PRICE.

ALL PURCHASING AGENTS WOULD BE WELL SATISFIED IF ALL CONSUMER GOODS GAVE SUCH SATISFACTORY SERVICE. THANKS TO YOU FOR A VERY FINE PRODUCT.

SINCERELY
EASTON MEMORIAL HOSPITAL
Harry A. Hyde
Purchasing Agent

The above unsolicited testimonial speaks for itself. We believe it is the most effective way of telling you that Anchor All-Nylon Surgeon's Brushes are not only the finest but the most economical on the market. In design, construction and quality, they are the last word in fine Surgeon's Brushes.

Anchor Brushes are guaranteed for a minimum of 400 autoclavings

Order only through

SELECTED HOSPITAL SUPPLY FIRMS

For information write

ANCHOR BRUSH COMPANY, Aurora, Illinois

Exclusive Sales Agents

BARNS COMPANY, 1414-A Merchandise Mart, Chicago 54, Ill.

"MODERNFOLD" DOORS prescribed for Improved Hospital Service

in Patients' Room

No wasted floor or wall space here! "Modernfold" doors have replaced old type swinging doors. Use the accordion-like action of these steel-framed, vinyl-covered doors to save approximately 8 square feet with every opening—in closing off rooms from corridors, in reception rooms, nurses' homes, internes' quarters.

. . . in Hospital Cafeterias

Another example of how "Modernfold" doors improve the service of a hospital! Large "Modernfold" doors are actually *movable walls* . . . can be used to control the size of any area. Use them also to create individual rooms from large areas . . . to separate doctors' offices from treatment rooms, in wards . . . wherever privacy is needed.

. . . throughout the Hospital

Wherever you install "Modernfold" doors, you gain long years of service. And maintenance is practically nothing. Vinyl covering is flame-resistant, will not crack, peel or fade . . . is easily washed with soap and water. Frame is made of tested *steel* parts.

For full details, look in your classified phone book for our installing distributor . . . or mail coupon.

Sold and Serviced Nationally

NEW CASTLE PRODUCTS
New Castle, Indiana

In Canada: **Modernfold Door Company of Canada, Limited, Montreal**

NEW CASTLE PRODUCTS
P. O. Box 965
New Castle, Indiana

Gentlemen:
Please send me full details on "Modernfold" doors.

Name.....
Address.....
City.....State.....

Want Advertisements

POSITIONS OPEN

LIBRARIAN—Record; 300-bed approved general hospital, in central Pennsylvania. Apply D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

LIBRARIAN—Record; male; for 150-bed new hospital; must be able to organize and set up department; northwest; excellent recreation area; population 35,000; salary to be discussed. MO 2, The Modern Hospital, 919 N. Michigan Ave, Chicago 11.

MISCELLANEOUS—Anesthetist and experienced Laboratory technician; immediately; highest salary and pleasant working conditions with most modern equipment. Applicants apply, Mrs. Bennett, Superintendent, The Lynn Hospital, 2950 South Fort Street, Detroit 25, Michigan.

MISCELLANEOUS—One Supervisor and one General duty nurse; meals while on duty and laundry of uniforms. Apply Business Manager, Floyd County Co-Operative Hospital; Lockney, Texas.

MISCELLANEOUS—Nurse administrator and two General duty nurses; for Valley Hospital, Palmer, Alaska; Director of school of nursing; Instructor in nursing arts and Public health nurse for Ganado Mission, Ganado, Arizona; General duty nurse for Embudo Hospital, Embudo, New Mexico; Graduate, single nurses with college degrees required for most positions; candidates must be in good health, interested in church affiliated hospitals, and willing to participate in religious program. Write, Presbyterian Board of National Missions, Room 708, 156 Fifth Avenue, New York 10, New York.

MISCELLANEOUS—1 Instructor; 1 Supervisor; maternity division; 50 building; large hospital; Bachelor's Degree, for teaching; 40-hour week. MO 6, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MISCELLANEOUS—Supervisor and Staff nurses; 130-bed Methodist hospital; new 300-bed building open about September, 1951 in Texas medical center; openings for Operating room supervisor, Scrub nurses, and General duty evening and night nurses; 44-hour week, 2 weeks' vacation after one year, 2 weeks' sick leave after 6 months, 6 holidays per year; salary starts at $200, plus one meal; University of Houston in city offers graduate study in nursing education. Apply, Assistant Director of Nursing, Methodist Hospital, Houston, Texas.

NURSE—Experienced graduate; for management of 18-bed home for chronic and convelescent patients, supervision of affiliated practical nurse students; salary $2400 and full maintenance, 1 month vacation; new building soon. Mrs. W. H. Richardson, 7 Chestnut Hill, Brattleboro, Vermont.

NURSES—Head; for 46-bed obstetrical floor and 29-bed communicable disease ward; also general staff nurses for medicine, surgery, obstetrics, nursery and operating room; 44-hour week; 4 weeks paid vacation. Apply Director of Nursing, Evanston Hospital, Evanston, Illinois.

(Continued on page 184)

NURSES—General duty; for 147-bed hospital; salary $215 per month with $10 differential for evening or night duty; also Surgery scrub nurse; $255 per month. Apply, Mrs. Ruth Garland, R.N., Superintendent of Nurses, Memorial Hospital of Natrona County, Casper, Wyoming.

NURSES—General duty; for 360-bed general hospital; starting salary $175 per month with maintenance; $200 per month with partial maintenance; rotating shifts; two weeks' vacation; 30 days' sick leave; 6 holidays yearly with pay; 44-hour week; college courses available through night classes at local university. Apply Director of Nursing, Greenville General Hospital, Greenville, South Carolina.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—General duty; for 45-bed general hospital; 40-hour week; paid vacation; sick leave; salary and working conditions to conform to requirements of state nurses association. Director of Nurses, Douglas Community Hospital, Inc., Roseburg, Oregon.

NURSES—Staff; New York registered; for operating room, bedside nursing; salary $200 per month with meals; 40-hour week. Apply, Superintendent of Nurses, New York Eye and Ear Infirmary, 218 Second Avenue, New York 3, New York.

Want Advertisements

POSITIONS OPEN

NURSES—General duty; 33-bed hospital; salary $185 per month; 4 weeks' vacation, sick leave. Apply, Superintendent, Nantucket Cottage Hospital, Nantucket, Massachusetts.

NURSES—Graduate general duty; for tuberculosis hospital; 44-hour week; good starting salary; full maintenance; 2 weeks' vacation; 8 paid holidays; liberal sick leave and retirement: Apply, Director of Nurses, Peoria Municipal Tuberculosis Sanitarium, Box 60, Peoria, Illinois.

NURSES—General duty; at once, for large general hospital; beginning salary $240 per month for evening or night duty; $60 deducted for single room, meals and laundry; $20 deducted for day duty; salary increased by $5 a month at three, six and twelve month intervals and annually thereafter; 44-hour week; overtime remuneration; opportunities for promotion. Address, Director of Nursing, Michael Reese Hospital, Chicago 16, Illinois.

RESIDENCIES—Available; surgery, medical, obstetrics and gynecology; beginning January 1, 1951; 300 beds; approved by AMA and ACS; board approval medical residency; active outpatient clinic and in-patient service. Inquire at once for details, Hackensack Hospital, Hackensack, New Jersey.

SUPERVISOR—Night; for 125-bed accredited general hospital with school of nursing; salary open; experience necessary. Apply, Director of Nurses, Columbia Memorial Hospital, Hudson, New York.

SUPERVISOR—Surgical; for progressive 100-bed general hospital with 50 student nurses; advanced preparations; salary open, maintenance. For further information write, Director of Nursing, Lutheran Hospital, Vicksburg, Mississippi.

SUPERVISOR—Pediatric; large general hospital maintaining 30-bed pediatric service; good personnel policies; advanced preparation necessary; salary open. Apply Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

SUPERVISOR—Night; for 50-bed hospital; 8-hour day, 6 day week; 11 p.m. to 7 a.m.; good salary for qualified person. Apply Catherine Booth Hospital, 4400 Walkley Avenue, Montreal 28, Quebec.

SUPERVISORS—Immediate opening in modern 65-bed hospital for an obstetrical supervisor and a medical-surgical floor supervisor 48-hour week; two weeks' vacation after one year's service; salary open. Write, Shawano Municipal Hospital, Shawano, Wisconsin.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU

Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

DIETITIANS—(a) Administrative; charge of employees cafeteria; large medical center, central states. (b) 175-bed hospital, eastern Pennsylvania. (c) 125-bed hospitals, Ohio, Michigan, Illinois, Texas, Virginia, North Carolina.

INTERSTATE—*Continued*

TECHNICIANS—(a) Chief laboratory; 125-bed Ohio hospital. (b) 100-bed new Texas hospital; $325.

RECORD LIBRARIANS—(a) 120-bed hospital, eastern Pennsylvania; $200, maintenance. (b) 100-bed Ohio hospital; $225. (c) 65-bed hospital, Florida.

EXECUTIVE HOUSEKEEPERS—(a) 400-bed hospital; east. (b) 125-bed hospital, Ohio; expansion program. (c) 150-bed hospital, Virginia.

ADMINISTRATORS—(a) 100-bed hospital; progressive town, West Virginia; $6,000. (b) 85-bed hospital, Ohio; to be completed in June, 1951. (c) 60-bed hospital, Texas. (d) 55-bed hospital, Indiana.

ASSISTANT ADMINISTRATORS—(a) 200-bed hospital, large industrial city; new building planned; business management experience desired; $5000. (b) Purchasing agent; 250-bed hospital, southern California. (c) Accountant; 300-bed hospital, Pennsylvania.

DIRECTORS OF NURSING—(a) 250-bed hospital, near Washington, District of Columbia. (b) 125-bed hospital, new and modern; New England; $4000, maintenance. (c) 175-bed Ohio hospital; $350. (d) 200-bed hospital, mid-western college town. (e) 300-bed hospital, medical center, south.

OPERATING ROOM SUPERVISOR—200-bed Ohio hospital; $350.

EDUCATIONAL DIRECTORS—(a) 300-bed hospital; attractive community, suburb large mid-western city. (b) 200-bed hospital, southeast; $325, maintenance.

(Continued on page 186)

Want Advertisements

POSITIONS OPEN

THE MEDICAL BUREAU

Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATORS — (a) Medical: 400-bed hospital, unit of large university group; opportunity of succeeding general director within several years. (b) General hospital, 350 beds; degree, considerable experience required; metropolitan area of the east. (c) General hospital, fairly large size; teaching affiliations; although medical administrator preferred, outstanding layman eligible; substantial salary including residence; east. (d) 100-bed general hospital currently under construction; health resort town, coastal city, southwest. (e) Modern well equipped hospital, 100 beds; small community; resort area, west. (f) Voluntary hospital, 150 beds, currently under construction; experienced administrator of broad training required; (g) Assistant, in charge of professional services; medical degree desirable; young layman with Degree in Administration eligible; large teaching hospital. (h) Assistant medical director; one of the country's leading teaching hospitals; formal training or experience not mandatory prerequisite. (i) Assistant to one of the country's leading lay administrators; large general hospital; Master's Degree required; east. (j) New hospital, small size; small town, Pacific Northwest. (k) General 225-bed hospital; spring building program will increase capacity to 300; graduate nurse experience in administering fairly large hospital eligible. MH 12-1.

MEDICAL BUREAU—*Continued*

ADMINISTRATORS-NURSES. (a) Small general hospital now under construction, completion expected January; residential town short distance from university medical center; midwest. (b) General hospital, 75 beds; college town, south. (c) General hospital currently under construction; residential town short distance from college town of 100,000; minimum $5000, east. (d) General hospital, 75 beds, modern, well equipped; college town, New England; preferably one with New England background. (e) To take charge of home for older persons, men and women; $5000-$6000, maintenance; university city, midwest. (f) See (k) under administrators. MH 12-2.

ANESTHETISTS — (a) Teaching hospital; service primarily surgical; university center, midwest; minimum $400. (b) General hospital, 125 beds operated by group clinic; $4200, maintenance; southwest. (c) Two; large teaching hospital; department directed by two medical anesthesiologists; research and teaching program; university center, southeast. MH12-3.

DIETITIANS — (a) Chief; fairly large general hospital; college town, east. (b) Chief; duties include supervising staff of 18; new hospital splendidly equipped; west. (c) Nutrition consultant; public health appointment outside continental United States. (d) Chief and assistant dietitian; dietary department in new wing under construction; 200-bed hospital; Long Island. MH12-4.

(Continued on page 188)

MEDICAL BUREAU—*Continued*

DIRECTORS — (a) Director school of nurses recently taken over by junior college; duties consist of organizing program, coordinating its scheduling problems between hospital and college; Pacific Coast. (b) Director of nursing service; new hospital to be opened for operation in April; fashionable suburb, eastern city. (c) Director of school and nursing service; one of the leading hospitals on the Pacific Coast; teaching affiliations; university town; substantial salary, maintenance including new penthouse apartment. (d) Director of nurses; 450-bed general hospital; teaching affiliations; 200 students; university medical center. (e) Director of school and nursing service; 500-bed hospital; collegiate program; university city. (f) Assistant director of nursing service; general 350 bed hospital; will consider pediatric or obstetrical supervisor with administrative ability; university town, midwest. MH12-5.

EXECUTIVE HOUSEKEEPERS — (a) Large general hospital; busy outpatient department, California; minimum $250. (b) General 225-bed hospital; college town, New England. (c) 500-bed teaching hospital; outstanding opportunity. MH12-6.

FACULTY APPOINTMENTS — (a) Educational director; 500-bed general hospital; 150 students; university medical center; midwest. (b) Nursing arts instructor; collegiate school; $3600-$4400; California. (c) Medical-surgical and nursing arts instructors; 60 students, university and college town; New England. MH12-8.

Want Advertisements

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

ADMINISTRATION PERSONNEL—(a) Purchasing agent qualified to assume control of centralized purchasing department; fairly large hospital, Pacific Coast. (b) Public relations director; general 300-bed hospital; university medical center, east. (c) Personnel director; 300-bed general hospital; east. (d) Chief accountant; 275-bed teaching hospital; university medical center; midwest; minimum $6500. (e) Executive secretary; state tuberculosis association; experience in association work desirable; south. (f) Purchasing agent; large hospital outside continental United States. (g) Lay or medical administrator to serve as general supervisor, two divisions, large teaching hospital; duties relatively light; east. MH12-7.

SUPERVISORS—(a) Obstetrical; 500-bed general hospital; college town, New York; $275, maintenance. (b) Psychiatric; newly created department in new wing of well established hospital; department averages 36 patients, principally private; college town, 100,000. (c) Floor; private and semi-private floor; 300-bed hospital; college town, midwest. (d) Operating room supervisor; large general hospital; university city of 200,000 located outside continental United States. (e) Operating room; fairly large general hospital, modern in every respect, operated by one of country's leading clinics; staff of distinguished specialists; outstanding opportunity. MH12-12.

MEDICAL BUREAU—*Continued*

MEDICAL RECORD LIBRARIANS—(a) First assistant; registered; five-day, 40-hour week; general voluntary hospital of large size considered one of California's most important. (b) Chief; qualified to re-organize and direct services in departments of three general hospitals, combined bed capacity 1200; large city, university center, Midwest; minimum $4000. (c) Chief; large general hospital; Connecticut; short distance from New York City. (d) To take charge of departments, three small hospitals; Southern California. MH12-9.

MALE NURSES—Several, graduate nurses for interesting foreign appointments; most desirable locations; duties consist of conducting first-aid stations; substantial salaries including maintenance. MH12-10.

PHARMACISTS—(a) Chief; large general hospital located on one of the islands in Pacific. (b) Small general hospital operated by group clinic; university medical center, midwest. (c) To teach pharmacy; small university; midwest. MH12-11.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
4707 Springfield Avenue
Philadelphia 43, Pennsylvania

ANESTHETIST—New England; starting $350; maintenance.

DIRECTOR OF NURSING—Assistant; open January, 1951; degree, $265, maintenance includes apartment.

(Continued on page 190)

MEDICAL PERSONNEL EXCHANGE —*Continued*

DIETITIAN—Chief; large hospital east; $4000; complete maintenance.

INSTRUCTORS—(a) Clinical; $3600. (b) Nursing arts; $2700; maintenance includes apartment.

SUPERVISOR—Operating room; to head department of surgery; 300-bed hospital; 40-hour week; salary open.

PSYCHOLOGISTS—(a) Male or female; 1900-bed mental hospital; MA acceptable; experience required; starting $3000; complete maintenance. (b) Male; penal institution; starting, $3600.

RECORD LIBRARIAN—Head; 450-bed general hospital; east; salary open.

MEDICAL STENOGRAPHER—State Department of Health; east; starting $3000.

LAUNDRY MANAGERS—Attractive openings; all locations.

No charge for registration

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

HOSPITAL SUPERINTENDENT—Nurse with training in hospital administration; 60-bed general hospital located in very progressive small southern town, close to large cities; hospital is well staffed and modern in all respects.

Your Responsibilities

A guide for Trustees and Administrative officials

You may obtain a free copy of this valuable booklet prepared by Insurance Company of North America. Trustees and Administrative officials of schools, colleges, universities, hospitals, churches, homes and similar educational or charitable organizations will find it a great help in the review of their responsibilities.

The booklet cites court decisions defining Trustee responsibilities for the preservation of properties, funds and assets. It explains the important role insurance plays in protecting you as you carry out your responsibilities, both legal and moral.

For your copy of this booklet, see the local Agent of any one of the North America Companies. If you do not know who he is, write us, and we'll be glad to introduce you.

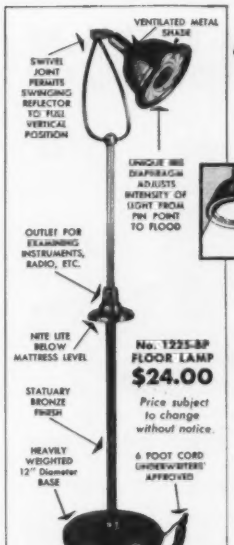
1792 PROTECTING AMERICA'S WEALTH SINCE 1792

Insurance Company of

North America

Companies, *Philadelphia*

Insurance Company of North America
Indemnity Insurance Company of North America
Philadelphia Fire and Marine Insurance Company

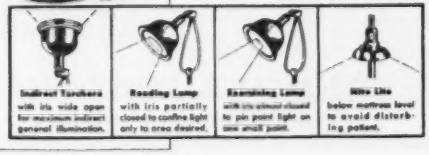


NEW... COMPLETELY DIFFERENT

The Hospital Floor Lamp with the IRIS EYE

Unique iris diaphragm adjusts light to any degree between pin point and full flood. With iris almost closed, light is concentrated on one small point. With iris wide open, full general illumination is obtained. Shade can be swung to any position. All metal construction; Statuary bronze finish. Comes complete with 60 watt bulb, 6 foot extension cord, and 7½ watt bulb for nite lite.

EICHENLAUBS
For Better Furniture
3501 BUTLER ST., PITTSBURGH 1, PA.
ESTABLISHED 1873



Sure Cure for Slippery HOSPITAL FLOORS

Rx Hillyard's Slip-Resistant Hilco-Lustre

Feet won't slip on Hilco-Lustre floors. That's why slip-resistant Hilco-Lustre is approved by Underwriters' Laboratories for underfoot safety.

FAST, EFFICIENT Liquid Hilco-Lustre spreads quickly. Requires no buffing or polishing. Dries in 30 minutes. Effective on every type of floor.

DURABLE Hilco-Lustre is rugged, hard. Protects expensive floor installations with a high gloss surface. Gives long-life durability under constant usage.

SPEEDS MAINTENANCE Hilco-Lustre saves you time and effort. Tough surface coat keeps dirt from digging in. Floors stay lustrous longer . . . need only occasional cleaning with HILLYARD'S Super Shine-All.

SAFE Hilco-Lustre is double-safe for your floors . . . safe to walk on, safe to use on any kind of floor surface.

HANDLE WITH HILLYARD CARE!

St. Joseph, Mo.

BRANCHES IN PRINCIPAL CITIES

Want Advertisements

POSITIONS OPEN

SHAY—*Continued*

ASSISTANT HOSPITAL ADMINISTRATOR—Middle west; 100-bed hospital fully approved; hospital is ideally located in residential section of city of 60,000; many amusement and cultural advantages within the city and at nearby universities; must be registered nurse with executive experience; $4000-$4800 to start.

PURCHASING AGENT—West; 160-bed hospital needs experienced man to assume control of their centralized purchasing department; purchases approximately $200,000 in merchandise and supplies per year; $300 minimum to start.

NURSE ANESTHETIST—Southwest; 417-bed teaching hospital; surgical cases average 300 a month, 90% of which are done under anesthesia requiring the services of an anesthetist; obstetric service is not covered by the department except for operative emergencies; on call only one night a month; $300 minimum to start.

DIETITIAN—East; large hospital; must have good experience and be A.D.A. member; department is well organized and has a very competent staff; equipment is all modern and living quarters are exceptionally nice; $4000 to start plus complete maintenance.

WOODWARD MEDICAL PERSONNEL BUREAU

(Formerly Aznoe's)

Ann Woodward, Director

185 North Wabash Avenue

Chicago 1, Illinois

ADMINISTRATORS—Lay: (a) 500-bed general hospital; extremely desirable tropical location; about $15,000. (b) 225-bed general hospital under construction; fairly large southwest university, winter and health resort city. (c) Medical; Canadian general hospital enlarging to 150 beds; large, eastern tourist city. (d) Lay; excellent opportunity for experienced man to build his own plant; fairly wealthy eastern community, 10,000, ready to erect general voluntary hospital. (e) Medical; fairly large west coast county hospital; to $12,000; well-furnished home on hospital grounds. (f) Lay; Spanish speaking; 250-bed neuro-psychiatric sanatorium; large island of American dependency; while location considered tropical climate is mild. (g) Medical; general hospital; 300 beds; duties chiefly administrative; prefer physician with hospital administrative experience; (h) Lay or medical; small general Arizona hospital, government supervised; 2 bedroom, fully furnished home. (i) Lay; assistant; general voluntary hospital; 200 beds; New England, college city 35,000; while male applicant preferred will consider well qualified woman. (j) Medical; assistant; large southern university hospital; Masters in Hospital Administration desirable though not essential. (k) Lay; general hospital; 60 beds; residential town 16,000 near medical center; south. (l) Lay; small general hospital adding 25 beds; pleasant town near Chicago. (m) New southern county hospital; Blue Ridge mountainous region; will seek immediate approvals; requires Masters in Hospital Administration; about $7000. (n) Lay; fully approved 300-bed general hospital; requires member, ACHA; large southwest city. (o) Administrator and medical director; tuberculosis hospital of small size; residential town adjoining large university, medical center metropolis; to $10,000; northeast. (p) Physician with extensive administrative experience to act as executive officer of important medical society; $12,000. (q) Lay; 150-bed general hospital industrial in character; city of 25,000; to $7000; southwest. (r) Lay; 60-bed general hospital; Yellowstone Park reigon; new completely furnished cottage adjoining hospital grounds. (s) Lay; 100-bed new general hospital; Ohio. (t) Lay; smaller, new, Pacific northwest general hospital; modern facilities. (u) Lay; eminently successful group established 1925 with clinic-hospital of 50 beds; $10-$12,000 plus 10% year end bonus; desirable resort city near Chicago.

ANESTHETISTS—(a) New, fifty-bed hospital, latest equipment and building construction; $4200 up, forty hour week; northwest. (b) Modern industrial hospital 20 beds; duties include supervision nursing staff; attractive location near Phoenix; $4500.

(*Continued on page 192*)

Want Advertisements

POSITIONS OPEN

WOODWARD—*Continued*

ADMINISTRATORS — NURSE. (a) General county owned smaller southern hospital under construction. (b) General city hospital opening early 1951; 40 beds; require administrator now; attractive town 5000 near large medical center city. (c) General hospital, 60 beds, near large university medical center; south. (d) Small hospital exclusive Chicago suburb, expanding soon to 50 beds; $4000 up. (e) Assistant; 150-bed approved general hospital vicinity Cincinnati; to $5000. (f) Assistant; general hospital, 200 beds, summer resort city 35,000; east.

ADMINISTRATIVE ASSISTANTS—(a) Purchasing agent; large California hospital; annual purchases exceed $200,000. (b) Office manager; large Chicago hospital; requires accounting background. (c) Business manager; general hospital; 50 beds; exceptionally well equipped and staffed; Illinois residential town adjacent to several large cities. (d) Credit manager; old established 9 man group; beautiful clinic building in residential section of rapidly expanding Missouri River town of 50,000. (e) Accountant; head department 300-bed general hospital; capable installing cost and budget system; Pennsylvania; about $4800.

ASSOCIATE DIRECTOR — Department of nursing; charge educational program large teaching hospital, eastern city 200,000; Master's Degree required; minimum $5500.

WOODWARD—*Continued*

DIETITIANS—(a) 200-bed approved general hospital adjacent state university center; minimum, $4000. (b) 270-bed hospital, expanding to 500 beds soon; unusually attractive location residential resort community near New York; $4200.

DIRECTOR OF NURSES—(a) Large, approved Hawaiian hospital; attractive location; $6000. (b) 300-bed approved hospital; southern university town, 200,000; minimum $5000.

ASSISTANT DIRECTOR OF NURSES—(a) Fully approved psychiatric hospital capacity 3000; pleasant fruit growing region adjacent Atlantic Coast; to $5000. (b) 200-bed approved general hospital, fairly large town; northeast coast, Hawaii; $4800.

EDUCATIONAL DIRECTORS—(a) Fully approved general hospital, north central educational center; $4500 minimum; apartment available. (b) 400-bed teaching hospital, student enrollment 100; excellent location near Philadelphia; $3600 minimum.

INSTRUCTORS—(a) Medical & surgical; 140-bed midwest teaching hospital, expanding to 250 soon; $3600. (b) Clinical; 200-bed approved hospital; city 75,000, lake resort area; $3600 minimum. (c) Nursing arts; 200-bed ultramodern hospital; city, 60,000; adjacent eastern educational center. (d) Science; 250-bed approved general hospital; west coast university town; five-day week; $3600.

(Continued on page 194)

WOODWARD—*Continued*

OPERATING ROOM SUPERVISORS — (a) Large, approved Hawaiian general hospital vicinity Honolulu; well staffed department; degree required; $3600 to $4000. (b) 200-bed university affiliated hospital; southern city, 200,000; excellent surgical set-up; minimum $3600.

RECORD LIBRARIANS—(a) Small, new, air-conditioned hospital adjacent Los Angeles and Palm Springs; 40-hour week, salary $3000, apartment available. (b) Chief; for large New York teaching hospital; staff of eight in department; to $3600.

SURGICAL SUPERVISORS—(a) Fully approved general hospital capacity 200; delightful community near Reno, Nevada; $4200 up. (b) Head large department, 300-bed teaching hospital, east coast state capital; $4000 up.

PLACEMENT BUREAUS

ALLEN AGENCY

512 Kales Bldg.

Detroit 26, Michigan

We have good opportunities in Michigan and the mid-west for medical personnel in all fields. Our service is confidential and carefully supervised by Esther Allen, Owner.

Want Advertisements

PLACEMENT BUREAUS

MEDICAL-DENTAL PERSONNEL BUREAU

OF SPOKANE

Mary Lowry, M.T., Director

525 Paulsen Bldg.

Spokane 8, Washington

Many Good Positions in All Medical Specialties

in the Great Northwest

Write us for full details.

ZINSER PERSONNEL SERVICE

Anne V. Zinser, Director

Suite 1004—79 West Monroe Street

Chicago 2, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

BROWN'S MEDICAL BUREAU (Agency)

7 East 42nd Street

New York City 17

If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director.

We Do Not Charge a Registration Fee.

FOR SALE

NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices wtih unexcelled service. Write Chicago Medical Book Company, Congress and Honore Streets, Chicago 12, Illinois.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS

400 East 59th Street, New York City

(Continued on page 196)

Equipment for sale. 1 GE Maximar 200 KVP-12 MA x-ray therapy unit with wall control stand. Tube only 6 months old. Machine in perfect operating order and presently in use. To be disposed of at greatly reduced cost. Call or write, Dr. C. Snead, Memorial Hospital, Elmhurst, Illinois. Phone Elmhurst 6800.

SCHOOLS—SPECIAL INSTRUCTION

WASHINGTON UNIVERSITY SCHOOL OF NURSING OFFERS the following Courses and Programs for the year 1950-51:

Programs leading to the degree, Bachelor of Science in Nursing:
- Advanced Psychiatric Nursing
- Community Health Nursing
- Supervision of Nursing Service
- Teaching in Schools of Nursing
- Ward Administration and Teaching

Special Advanced Professional Courses:
- Advanced Psychiatric Nursing (twelve months)
- Advanced Clinical Practice in Operating Room Technique (four months)

For further information write to the Director, Washington University School of Nursing, 416 South Kingshighway, St. Louis 10, Missouri.

Want Advertisements

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of $60 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

JERSEY CITY MEDICAL CENTER SCHOOL OF NURSING offers to qualified graduate nurses a four-month course in operating room technic. Full maintenance and stipend granted. Apply to Director of Nurses, Jersey City Medical Center, Jersey City, N. J.

SCHOOL FOR LABORATORY TECHNICIANS —Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

Four Months' Course:

Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

Six Months' Course:

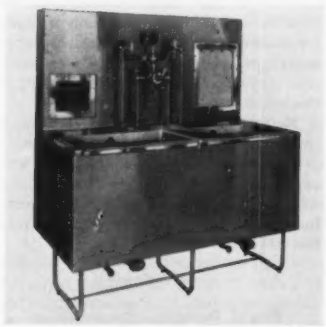
Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

What's New for Hospitals

DECEMBER 1950 Edited by BESSIE COVERT

Developing Tank



A new line of stainless steel developing tanks is being introduced for x-ray department darkrooms. They are strong, light in weight and nonwearing. Built-in insulation prevents sweating and cuts heat transfer in the tanks, each having 1½ inch spunglass between the inner and outer shell on all four sides and on the bottom. A 30 inch self-contained refrigerated master tank can be used, with copper cooling coils installed between the inner and outer walls, by those in areas where tap water rises above 65 degrees F.

The steel used in the tanks is a special alloy designed to resist the corrosive action of photochemicals. It is also chemically treated to ensure chemical resistance. Little effort is required to clean the tanks and keep them spotless. The tanks are made in three standard sizes which can be arranged in multiples to suit the needs of darkrooms of various sizes and work loads. **General Electric X-Ray Corp., Dept. MH, 4855 Electric Ave., Milwaukee 14, Wis. (Key No. 860)**

Improved Anacap Silk

Five outstanding qualities are claimed for the new improved Anacap Surgical Silk recently introduced by Davis & Geck. They include greater tensile strength, non-capillarity so that it resists bacterial invasion and withstands effects of body fluids and moisture, easier handling since it does not become limp when moist but retains flexibility and pliability, continued strength after repeated sterilization and economy of material. **Davis & Geck, Inc., Dept. MH, 57 Willoughby St., Brooklyn 1, N. Y. (Key No. 861)**

Static-Free Microtome

A static eliminator containing a surface plated with polonium, a member of the uranium-radium radioactive series of elements, is placed about an inch from the blade of a new static-free microtome to permit the cutting of tissue sections without the inconveniences frequently encountered from static. The alpha radiation from the polonium ionizes the air and discharges static electricity as it forms, leaving an easily handled ribbon of tissue. **American Optical Co., Scientific Instrument Div., Dept. MH, Buffalo 15, N. Y. (Key No. 862)**

Liquid Dispenser

Any fluid, from maple syrup to coffee cream, hot or cold, can be dispensed from the new Polar Ware Agimatic Liquid Dispenser. The amount dispensed can be accurately controlled

from ½ ounce to 4 ounces in one stroke of the lever.

The Agimatic pump, a simple patented assembly, automatically agitates all fluids with every stroke so that fruit and vegetable juices or soup or puree are dispensed uniformly for all servings. Nothing can drip into the contents of the dispenser. It is made of stainless steel and can be taken apart for cleaning in 30 seconds and reassembled in the same time. There are few parts and the double walls are insulated with Fiberglas. Thus hot beverages or soups can be kept hot for approximately two hours and cold drinks remain chilled for a six-hour period when the ice compartment at the bottom of the dispenser is filled. **Polar Ware Company, Dept. MH, Sheboygan, Wis. (Key No. 863)**

Rust Inhibiting Germicide

No rust or film will form on instruments disinfected with the new permanent rust inhibiting germicide concentrate known as R.I.G., according to the manufacturer. Instruments left immersed in the solution for six months on a test basis revealed no pitting or loss of cutting edge.

The concentrate is colorless, odorless and stable, both before and after mixing. It has a high germicidal efficiency against many types of pathogenic bacteria but contains no mercury, phenol or formalin. It is non-toxic, non-irritating and may be used safely on metal, rubber, plastic and glass instruments and appliances. It is said to retain its rust inhibiting and germicidal properties as long as it is in use or until discarded.

R.I.G. concentrate is packaged in 10 ml. ampules and is diluted with one liter of soft or hard water to make a highly efficient, rust inhibiting germicide. It is also available in pint cans for hospital use. **Clay-Adams Co., Inc., Dept. MH, 141 E. 25th St., New York 10. (Key No. 864)**

Combination Pad

Eight alternate layers of highly absorbent cotton and cellulose, backed by one layer of nonabsorbent cotton, all securely gauze-wrapped to prevent bulging or separation, make up the new combination pads and rolls introduced by The Carolina Absorbent Cotton Company. Specifically designed to control absorption and drainage, the new combination pads and rolls offer a maximum of protection against staining of garments and sheets.

The pads are available in seven convenient sizes as well as in rolls which are eight inches wide and 20 yards

long. **The Carolina Absorbent Cotton Co., Dept. MH, P.O. Box 2176, Charlotte 1, N. C. (Key No. 865)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 208

Blade Sterilizing Jar

The new, improved Bard-Parker Blade Jar has been increased in diameter to permit easy removal of individual blades from the blade rack with B-P Transfer Forceps without taking the rack out of the disinfecting solution, thus maintaining the chain of sterility. The blade rack handle has been shortened to permit complete submersion of the unit in the solution. When desired, the blade rack may be removed from the jar for draining or replacement of blades. Suspended immersion of B-P blades in the disinfecting solution without damage to the keen cutting edges due to contact with other blades or jar surfaces is possible with the new Blade Jar. **Bard-Parker Company, Inc., Dept. MH, Danbury, Conn. (Key No. 866)**

Toilet Partitions

A new type of toilet partition is being introduced which requires no overhead supports or braces and no posts to the floor. Known as Wal-Sa-Port, the partitions employ a cantilever type suspension which is permanent, rigid and is said to withstand hundreds of pounds of weight on its forward edge. The elimination of floor supports simplifies floor cleaning problems.

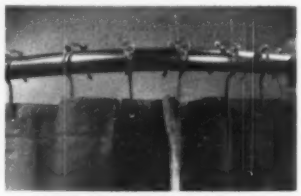
All construction is non-metallic, eliminating deterioration by corrosion and rust, and doors close quietly. Wal-A-Port Toilet Partitions are available for any compartment 2 feet 6 inches wide or over and can be installed in series with any number desired. **J. C. Petterson Co., Dept. MH, 3169 W. Mission Rd., Alhambra, Calif. (Key No. 867)**

Dietetic Tuna

Years of biochemical and nutritional research have resulted in the development of Chicken of the Sea Brand Dietetic Tuna, a special purpose food for use in dietotherapy. The product is high in protein content and contains all essential amino acids in well proportioned amounts. Dietetic Tuna has low fat content, practically no carbohydrates, is low in cholesterol and low in sodium. Investigation has indicated its usefulness as the basic food where overweight is to be combatted without altering protein balance. It has also proved valuable for the dietary treatment of some hepatic and renal diseases where high protein diets are advisable and represents a valuable source of protein in post-operative cases. Chicken of the Sea Brand Dietetic Tuna has been accepted by the Council on Foods and Nutrition of the American Medical Association. Literature on its composition and suggested uses is available from **Van Camp Laboratories, Dept. MH, Terminal Island, San Pedro, Calif. (Key No. 868)**

Curtain Rollers

The curtains used in cubicles to screen patients' beds can be opened and closed with a minimum of noise with the new Aeroflex plastic rollers fitted on curtain hooks. Made of polyethylene, a light, tough plastic, which absorbs practically no moisture, Aeroflex rollers do not stick



to the bar at any point, roll easily and since they are the only contact with the metal bar when the rollers are placed on each hook, friction and noise are minimized. Aeroflex rollers are extruded by Anchor Plastic Company for **A. R. Nelson Co., Dept. MH, 210 E. 40th St., New York 16. (Key No. 869)**

Compressor

A new 9 cylinder refrigeration machine has been added to the line of Frick New "Eclipse" Compressors. This makes the line now available in five sizes, the new one having a nominal capacity on air conditioning work of 90 tons of refrigeration. The new machine has three banks of cylinders. The angle between the vertical cylinders in the center and the banks at the sides is arranged to give an even torque on the shaft. Operation is smooth, sufficient lubrication is certain, due to the design, the crankshaft is dynamically balanced for smooth running and the bearings are precision made and designed for long wear. **Frick Company, Dept. MH, Waynesboro, Pa. (Key No. 870)**

Post Operative Stretcher

The new Model 1177 J & J Post Operative Stretcher has guard rails completely surrounding the litter to prevent the patient from falling off. When raised the rails are securely locked together, making a rigid guard 15 inches high around the entire letter. A new method of quickly elevating one end of the litter to Trendelenburg position is provided. An irrigator standard, which can be attached at any one of four different points on the litter, is provided and provision is made for holding arm rest boards at any of four appropriate positions. Provision is also made for four restraining straps if needed.

The stretcher is mounted on eight inch swivel csaters, two of the casters being provided with Magic Swivel Locks and two with brakes locking both swivel and wheel simultaneously. **Jarvis & Jarvis, Inc., Dept. MH, Palmer, Mass. (Key No. 871)**

Royal Portable Typewriter

The 1951 Royal Portable Typewriter is available in two new models, the new Quiet DeLuxe and the Arrow. Both models have several important features, among them the "Magic" Margin system for both left and right margin, operated by convenient new black plastic control buttons. The machines have a new plastic key Speed King Keyboard which is identical with the Royal office typewriter in positioning of letter keys and control keys and in all dimensions, including key size and slope. This permits easy transition by students and others from the standard to the portable machine.

Triple spacing, an adjustable paper support, "Picture Window" writing line visibility, a paper lock scale synchronized with all other scales on the typewriter, and redesigned, larger carriage control levers are other improvements on the portable models. An Automatic Carriage Centralizer automatically moves the carriage to center position as the lid of the new Contour Case is closed. The case is a tapered, tweed-patterned luggage-type

carrier. The curved surfaces increase both durability and attractiveness. **Royal Typewriter Co., Inc., Dept. MH, 2 Park Ave., New York 16. (Key No. 872)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 208

Pot and Pan Washer

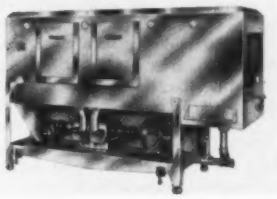
The new Model MK Panhandler is a more compact unit for cleaning pots and pans while retaining all the efficiency features of the Model K. It occupies a floor space of only 3 feet 4 inches by 4 feet 8 inches. Powerful fan-shaped sprays of cleaning solution are used which are said to remove, in one washing, even the most obstinate residue from pots and pans. The length of washing time can be varied to suit conditions. The washing period is automatically followed by a hot sterilizing rinse. The new unit is designed to wash all sizes of pots, roasting pans, steam table pans, kettles, utensils and mixing bowls. **The Alvey-Ferguson Co., Dept. MH, Cincinnati 9, Ohio. (Key No. 873)**

Free-Flow Salt Shakers

Attractive in design and practical in use, the new Airko free-flow salt shakers have the "Airkonite" element sealed in the chromium top to absorb any moisture in the air. Thus salt is always free-flowing, even in the dampest weather. The element reactivates itself indefinitely, thus ensuring a constant salt flow as desired. The shakers are made of glass with a hand-cut satin-finish base and are four inches high. **Airko Mfg. Co., Dept. MH, Clermont, Fla. (Key No. 874)**

Autosan Dishwashing Machines

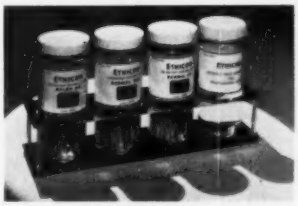
Three new Colt Autosan dishwashing machines are now available with built-in pre-flush chambers to eliminate hand scrapping of soiled tableware. Autosan Models RC-20, R-30 and R-40 have the pre-flush spray which is operated through a lever-controlled valve by the passage of dish racks at the loading end of the machine. A large capacity drawer scrap tray is provided for easy cleaning of food waste. Sixteen nozzles, eight above and eight below, housed in the hood extension at the loading end of the machine comprise the pre-flush spray. Time, labor and space are saved with the pre-flush unit as an integral part of the dishwashing machines.



The pre-flush machines have both the standard left to right feed drive and reverse right to left feed drive. A dial type flush-mounted thermometer is furnished for each tank and one each for the pre-wash and sanitizing sprays. Machines are constructed of polished stainless steel with adjustable feet for proper alignment. The conveyor is of the heavy roller chain type equipped with lugs for positive rack propulsion. Vertical sliding, leakproof doors at the front of the hood provide easy access to the interior and all working parts can be easily removed without the use of tools. The three machines provide capacities ranging from 2400 to 6000 dishes per hour. **Colt Manufacturing Co., Dept. MH, Hartford, Conn. (Key No. 875)**

Ethicon Surgiset

A decorative, convenient unit has been designed by Ethicon to provide a complete assortment of skin closure and emergency sutures for general use. Known as Surgiset, the unit contains three dozen Atraloc eyeless needle sutures in three wide-mouthed screw-cap Sterile Pack jars with an extra jar for miscellaneous sutures that may be needed. All jars are held in an attractive, chrome plated rack.



It is not necessary to boil suture tubes prior to use as tubes are kept sterile by a germicide in the bottles. The sutures selected for Surgiset are those required to take care of almost any type of minor surgery, thus making them readily available at a moment's notice in the hospital or in the ambulance. **Ethicon Suture Laboratories, Inc., Dept. MH, New Brunswick, N. J. (Key No. 876)**

Vegetable Peeler

A new model of the Univex portable electric vegetable peeler has recently been introduced with automatic timer. Made of stainless steel, for drainboard installation, the peeler operates by abrasive action on the vegetables. It is designed to peel 20 pounds of vegetables in one minute. The automatic dial timer prevents overpeeling and makes watching unnecessary. The machine is simple to operate, sturdy in construction and the few parts are readily accessible and easily replaceable. **Universal Industries, Dept. MH, 360 Mystic Ave., Somerville 45, Mass. (Key No. 877)**

Portable Darkroom

Economy and space-saving efficiency are claimed for the new Picker Portable Darkroom recently introduced. It requires only 29 by 44 feet of floor space and is completely self-sufficient. Everything needed to process x-ray films correctly is available in the unit. The door is equipped with light-baffle louvers for adequate ventilation and can be locked from the inside.

The unit contains a three-compartment processing tank against one end, a swinging shelf which can be lowered to provide a workbench for loading cassettes and other jobs, and which snap-locks against the wall when developing film, and two easily reached shelves for ample storage space of films, timer and other equipment. The exterior is finished in olive green enamel and the interior is painted orange for good reflection when working under the safelight. **Picker X-Ray Corp., Dept. MH, 300 Fourth Ave., New York 10. (Key No. 878)**

Unit Heaters

A new line of National Unit Heaters for institutional space heating has been announced. They can be used on either steam or hot water heating systems to secure a horizontal or down flow vertical delivery of warmed air and are available in 24 different sizes of horizontal units and 16 different sizes of vertical units.

Standard and heavy duty cores are available, both fabricated from seamless copper tubing. Rippled aluminum fins are bonded by a hydraulic expansion of the copper tubes. Fans are of the propeller type and motors are made specifically for fan duty. The heaters are designed for quiet operation and cabinets have a baked-on crinkle finish to resist corrosion. Different anemostats and diffusers for the vertical models are available as well as motors of different characteristics for all models. All necessary controls for the installation of heaters, including thermostats, starters and limit and speed controls, are also available. **The National Radiator Co., Dept. MH, Johnstown, Pa. (Key No. 879)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 208

Utility Cart

A general Utility Cart, sturdily constructed for hard usage, is available equipped with a heavy-duty can opener

as an integral part of the cart. This permits canned foods to be loaded at the storeroom and easily wheeled to the point where they are to be served, then opened. Thus large quantities of foods can be carried in one trip.

The cart has three shelves and is equipped with silent, rubber-tired, swivel wheels and rubber bumpers. It can also be provided without the can opener for general utility use. **Gennett & Sons, Inc., Dept. MH, Richmond, Ind. (Key No. 880)**

Salamander Broiler

Smaller hospitals with limited requirements for broiling and larger hospitals which need supplementary broiling equipment will be interested in the new Salamander broiler which has recently been added to the Garland line of cooking equipment. The Salamander broiler saves floor space since it fastens to the range in the same manner as a high shelf. The multi-port cast burners have ceramic radiants for quick, even heat distribution and are front-fired for greater heat flexibility. The grid is quickly raised or lowered by a convenient, front located lever. **Detroit-Michigan Stove Co., Dept. MH, 6950 E. Jefferson St., Detroit 31, Mich. (Key No. 881)**

Steam Trap

A brass strainer is built into the body of the new small inverted bucket steam trap recently introduced by Armstrong Machine Works. Known as the No. 881, the trap is used for draining smaller sized equipment producing relatively small amounts of condensate, such as sterilizers, laundry presses, coffee urns, jacketed kettles, unit heaters and vegetable steamers. The built-in strainer eliminates the need for separate strainer, extra fittings and installation labor. **Armstrong Machine Works, Dept. MH, Three Rivers, Mich. (Key No. 882)**

Dishwashing Machine

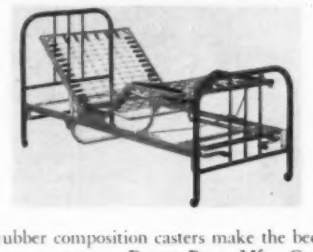
The new Model "W" Universal Roll Top Type Dishwashing Machine makes possible efficient dishwashing at low cost. The new model has welded steel construction and is available in galvanized or stainless steel. Washing action is produced by revolving sprays above and below baskets. The machine uses only 1¼ gallons of water for each rack of dishes.

The wash system is operated by a ¼ h.p. motor with maximum hourly consumption of 25 gallons of 180 degree rinse water and five gallons of 140 degree wash water. The machine is compact in design and can be installed under a counter or attached to dish tables. **Universal Dishwashing Machinery Co., Dept. MH, 87 Windsor Place, Nutley 10, N. J. (Key No. 883)**

Dual-Hite Gatch Bed

The Foster Dual-Hite Gatch Bed will accommodate the No. 9 Gatch Spring at fabric heights of either 26 or 16 inches so that it can be raised for nursing care and lowered for patient comfort and convenience. The spring elevation is easily changed in a minimum of time and all standard gatch spring adjustments may be attained at either level.

The bed is of simple lightweight construction and has the standard 2 crank gatch spring with horizontal telescoping cranks. It is built of heavy tubing and finished in brown enamel. Two inch



rubber composition casters make the bed easy to move. **Foster Bros. Mfg. Co., Dept. MH, 811 Broad St., Utica, N. Y. (Key No. 884)**

Adhesive Remover

"Quit" is the name of a new formula for the painless removal of adhesive tape It releases surface tension between skin and tape and leaves no gummy residue on the skin. It can be used effectively on single layer or multiple layer tapings. It is packaged in "squeeze" bottles which have spouts to permit drop or flow application. It is sold in 2 ounce and 4 ounce plastic applicator bottles which can be refilled, and in half pint, pint and quart labeled cans. **Patron Chemical Corp., Dept. MH, 8506 Sunset Blvd., Los Angeles 46, Calif. (Key No. 885)**

Floor Maintenance

A new line of floor maintenance materials is being introduced by Multi-Clean Products. Included are Multi-Clean Anti-Slip Waterproof Floor Wax for use on wood, asphalt tile, rubber tile, linoleum, concrete, terrazzo, magnesite and quarry tile floors to provide an easily applied, attractive, long-lasting, resilient finish which is not slippery; Multi-Clean Penetrating Sealer for wood floors to leave a smooth, resilient surface that requires less attention; Multi-Clean Floor Preserver which penetrates the fibers and cell structure of the floor to provide a more durable flooring surface; Multi-Clean Neo-Dry Concrete Sealer with a rubber base which is an easily applied, fast-drying, durable finish for concrete floors or other concrete surfaces, and Multi-Clean Concrete Preserver with a bakelite base for use on either old or new concrete, indoors or outdoors, to eliminate chipping, flaking and dusting and to provide a tough, sanitary surface highly resistant to abrasion and to water, grease, oils, alkali or soap. All products in the new line are made to special formulas and are carefully made of finest ingredients. **Multi-Clean Products, Inc., Dept. MH, 2277 Ford Pkwy., St. Paul 1, Minn. (Key No. 886)**

Adjusto Crutch

The Adjusto Crutch is made of light weight aluminum tubing. It extends to a full length of 57 inches or can be telescoped down to 32 inches. A double lock on the length adjustment keeps the holes in the tube from wearing and the spring loaded pawl for locking and adjustment is tested for strength up to 400 pounds. The Adjusto Crutch is easily adjustable, is light in weight and takes up a minimum of space. It comes in but one size and can be used in either the left or the right hand. **Everest & Jennings, Dept. MH, 761 N. Highland Ave., Los Angeles 38, Calif. (Key No. 887)**

Baker's Oven

Front-mounted drive and burner to save space, maximum bun pan capacity per square foot and inside roller chain drive and inside main bearings are features of the new 12 bun pan Fish "75" baker's oven. It is a compact unit, easily installed and occupying a minimum of floor space. The oven has been built for trouble-free service, without excess weight, with spiders and trays of square tubing for maximum strength. Standard equipment includes vitreous porcelain enamel front with flush-mounted controls, minute-minder timer and tray indicator. **Fish Equipment Co., Dept. MH, Beloit, Wis. (Key No. 888)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 208

Insecticide

A new low cost aerosol insecticide that can be used for both intermittent and continuous spraying is known as Safe-Lex. It is a self-spraying insecticide with a new and different formula containing DuPont Methoxychlor. A light touch on the lever of the dispenser releases a fine insecticidal mist which reaches into cracks, crevices and under base boards and is effective against flies, fleas, mosquitoes, ants, roaches and silver fish. By inserting a paper clip or pin into the mechanism a continuous spray can be maintained for over night decontamination.

The spray is safe to use around food and people, kills quickly and comes packaged in a light hermetically sealed container which, when full, weighs 16 ounces. The insecticide is non-inflammable, non-staining, easy to use and pleasantly scented. **Bostwick Laboratories, Inc., Dept. MH, 706 Bostwick Ave., Bridgeport 5, Conn. (Key No. 889)**

Copying Unit

The new Varifile is a fully automatic photographic copying unit employing standard 70 mm. roll film. Standard 35 mm. micro copy film can also be used with the machine. Automatic camera operation and other automatic controls permit simplicity and speed of operation with economy. The Varifile camera magazine has the motor and film metering equipment built in as integral parts. All magazines are interchangeable, permitting almost constant operation, or a rapid change from black and white to color or from 70 mm. to 35 mm.

The Varifile unit is available in two sizes, the Varifile Master which is complete, including table, and is designed to handle material to be copied up to 34 by 44 inches, and the Varifile Standard, a semi-portable model made for use where copying requirements do not exceed 24 by 36 inches in size. **Photographic Products, Inc., Dept. MH, 6919 Romaine St., Hollywood 38, Calif. (Key No. 890)**

Floor Seals

Four-hour drying time is claimed for two new floor seals introduced by Turco Products. No-Per-Vex is a nonpenetrating surface type seal for glossy finish. Nu-Vex is a deep penetrating material for use where a satiny wax finish is desired. Both seals can be applied with lamb's wool applicators. The seals require no dilution or thinning and meet the requirements of the Maple Flooring Manufacturers Association and of federal specifications, according to the manufacturer. The fast drying feature makes them of interest for institutional use since it reduces the time an area must be closed to use. **Turco Products, Inc., Dept. MH, 6135 S. Central Ave., Los Angeles 1, Calif. (Key No. 891)**

Patient Chair

A new chair, which is attractive in appearance, high and firm enough to be comfortable for patients when they can sit up out of bed, and from which they can easily get up to return to bed, is also suitable for visitors in the patient's room. It has been designed by Leon Gordon Miller especially for hospital use as a combination patient and visitor chair. It is upholstered in sturdy plastic, is solidly constructed and is 34½ inches high and 26½ inches deep. **Krolan Chair Mfg. Co., Dept. MH, 4619 Perkins Ave., Cleveland 3, Ohio. (Key No. 892)**

Cleanser for Plastic Tableware

Stains from coffee, tea and other foods can be removed from plastic tableware with the new M-E Plastic Cleaner. This oxygenating compound contains no chlorine and is not injurious to the plastic material, according to the manufacturer. The compound is odorless and tasteless and sanitizes as it cleans. Stains are removed by merely dipping tableware into the compound. **Maid-Easy Cleansing Products Corp., Dept. MH, 25 Elm Ave., Mount Vernon, N. Y. (Key No. 893)**

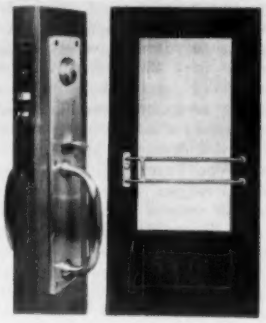
Conductive Sole Shoe

The new Tomac Conductive Sole Shoes are said to conform to the recommendations of the National Fire Protection Association in the manual, "Recommended Safe Practice for Hospital Operating Rooms." The shoes are an important contribution to the hospital's safety program because they serve to ground body static before it can cause a spark.

Tomac shoes are made with a conductive sole and heel plus a conductive sock lining that ensures the grounding of body static whenever one shoe is in contact with the floor. The shoes are available for both men and women and are built for comfort and appearance. Women's shoes are obtainable in moccasin style or high heel. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 894)**

Steel Doors and Door Hardware

New latch-type door hardware for entrance doors has been designed for use



on steel doors used wherever light is needed. The glass-paneled steel door with large glass area may be hinged right or left, to swing in or out, and may be used as a single or double door. It has a wide variety of uses including athletic stadiums, building entrances and other locations. The doors are shipped in complete units, including doors, frames and hardware. They are easily installed, offer low upkeep and are fire-safe and quiet. **Detroit Steel Products Co., Dept. MH, 2250 E. Grand Blvd., Detroit 11, Mich. (Key No. 895)**

Stencil Duplicator

A new hand operated stencil duplicator has recently been introduced by Niagara. Known as the "Q" Stencil Duplicator, the new machine incorporates all features of the Niagara line, including the Speed-Sheeter. It is sturdily constructed with simplicity of line and is designed for trouble-free operation. **Niagara Duplicator Co., Dept. MH, 725 Second St., San Francisco 7, Calif. (Key No. 896)**

Butter Pats

A new machine, known as the Patty-Hander, is designed to carry enough butter to dispense 360 pats from one loading of quarter prints of butter. The machine can be set to cut from 90 to 120 pats per pound, as desired. The pats are always cold as the Patty-Hander uses cube or cracked ice to keep the butter in good condition. A touch of the lever serves one pat of butter at a time, as needed, thus keeping the butter clean and sanitary.

The Patty-Hander is constructed of stainless steel throughout and is easily taken apart for cleaning and as easily reassembled. **Sales Engineering Corp., Dept. MH, 227 N. E. Eighteenth Ave., Portland 14, Ore. (Key No. 897)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 208

Antiseptic Liquid Soap

"Dysept" liquid soap is designed for use by doctors, nurses and other hospital personnel to help destroy and inhibit the growth of the majority of skin surface bacteria. Containing hexachlorophene, Dysept increases in effectiveness through continuous use. Thus when it is used regularly, skin surface bacteria are reduced to a minimum. Perspiration odor is also checked since the bacteria which cause it are destroyed by hexachlorophene. When used regularly by surgeons and surgical nurses the scrub-up time can be reduced. **The Davies-Young Soap Co., Dept. MH, Dayton 1, Ohio. (Key No. 898)**

Freeze-Drying Unit

A small compact unit for general research and small scale production of guinea pig complement, cultures, serums, vitamins and other biologicals is offered in the new Stokes Model 203-L Freeze Drying equipment. Drying and freezing are done in a tank at the top of the chamber on an electrically heated and thermostatically controlled drying shelf. A stainless steel dry ice condenser finger prevents water vapor from reaching the vacuum pump. Freezing is observed through a sight-glass in the lid of the freezing unit. The new model can also be supplied with chemical desiccant in place of the dry ice equipment or with both. **F. J. Stokes Machine Co., Dept. MH, 5900 Tabor Rd., Philadelphia 20, Pa. (Key No. 899)**

Locked Floor Drain

A new Josam floor drain has recently been introduced with a solid brass hinged top which can be locked in position with a removable key. Thus the grate is tamperproof and is especially suited for use in mental institutions and seclusion rooms. It can also be used to advantage in public areaways and similar locations. **Josam Mfg. Co., Dept. MH, 1302 Ontario St., Cleveland 13, Ohio. (Key No. 900)**

Automatic Cutoff

Burnout of water stills due to insufficient water from any cause can now be prevented. The new Lectrol Automatic Low Water Cutoff electronically shuts off the heat source when the water supply to the evaporator is insufficient and turns the heat on again when the water supply returns to normal. A Neon signal light indicates that the unit is in operation and an on-off switch on the side of the control box shuts off both control box and still. **Precision Scientific Co., Dept. MH, 3737 W. Cortland St., Chicago 47. (Key No. 901)**

Pharmaceuticals

NPH Iletin

NPH Iletin (Insulin, Lilly) is an improved insulin product which has been in process of development for several years. It is an intermediate-acting insulin which conforms closely to the daily needs of the average diabetic patient. The effect of NPH Iletin (Insulin, Lilly) is comparable to the action of mixtures of two parts unmodified insulin and one part Protamine, Zinc and Insulin. It is available in concentrations of 40 units per cc., and 80 units per cc. in 10 cc. vials. **Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 902)**

Dayalets

Dayalets contain eight synthetic vitamins plus vitamin B_{12}. These multiple vitamin tablets contain synthetic vitamin A to obviate the possibility of allergic reaction to fish oils. The tablets are compressed, sugar-coated and have the aroma of vanilla. They are supplied in bottles of 50, 100, 250 and 1000 tablets. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 903)**

Carboxy Methyl Cellulose

Stuart CMC, Carboxy Methyl Cellulose, is a non-irritating bulk laxative in capsule form for use in corrective treatment of the more common types of constipation. It contains carboxymethylcellulose, a new colloidal laxative. The capsules are easy to take and are sold in bottles of 100. **The Stuart Company, Dept. MH, 234 E. Colorado St., Pasadena 1, Calif. (Key No. 904)**

Dram-Cillin With Sulfonamides

White's Dram-Cillin with Triple Sulfonamides provides additive, antibiotic-chemotherapy against organisms susceptible to penicilllin-sulfonamide mixtures. It is a product for oral administration which is pleasant tasting and comes in 60 cc. bottles containing dry powder to which water is added at time of dispensing. **White Laboratories, Inc., Dept. MH, 113 N. 13th St., Newark 7, N. J. (Key No. 905)**

Prulose Complex

Prulose Complex is a dehydrated prune concentrate fortified with an isatin derivative combined with methylcellulose to produce activated moist bulk. It is designed for the therapeutic correction of functional constipation and is supplied in small tablets in bottles of 100. **The Harrower Laboratory, Inc., 930 Newark Ave., Jersey City 6, N. J. (Key No. 906)**

NPH Insulin Squibb

NPH Insulin Squibb is a highly purified aqueous suspension of crystals containing insulin, protamine and zinc. It differs markedly from Protamine Zinc Insulin as it contains protamine sulfate added in carefully determined amounts. The resultant preparation combines much of the immediate effect of unmodified insulin and of the prolonged effect of protamine zinc insulin. The product is supplied in two strengths, designated as U-40 and U-80, containing, respectively, 40 units and 80 units per cc. in 10 cc. square vials. **E. R. Squibb & Son, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 907)**

Biosulfa

Biosulfa Compressed Tablets are a combination of penicillin and sulfonamides which are said to exert an additive or synergistic antibacterial effect. Each tablet contains 100,000 units crystalline penicillin G potassium, 0.25 Gm. sulfadiazine, 0.25 Gm. sulfamerazine and 4 grs. calcium carbonate. Biosulfa is used in the treatment of pneumonias, gonorrhea, mastoiditis and other infections caused by organisms susceptible to penicillin and the sulfonamides. The tablets are available in bottles of 50. **The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 908)**

Neovacagen

Neovacagen is an oral vaccine tablet combined with an antihistaminic compound recommended to stimulate specific immunity against secondary bacterial invaders in respiratory infections. Neovacagen Tablets are also useful for prevention of the more serious complications that sometimes follow upper respiratory infections. They are supplied in bottles of 20 and 100 tablets. **Sharp & Dohme, Inc., Dept. MH, 640 N. Broad St., Philadelphia 1, Pa. (Key No. 909)**

Vasoxyl

Vasoxyl brand of methoxamine hydrochloric injection is a new potent synthetic vasopressor with prolonged action for use during surgical anesthesia. It produces a prompt and prolonged rise in blood pressure following parenteral administration and is thus a valuable agent for maintaining or restoring blood pressure during operative procedures. It is free from central stimulating action and does not produce cardiac arrhythmias. It is also available as Vasoxyl-P, methoxamine and procaine injection. Both products are supplied in 1 cc. ampules in boxes of 12 and 100. **Burroughs Wellcome & Co. (U.S.A.) Inc., Dept. MH, Tuckahoe, N. Y. (Key No. 910)**

Address manufacturers for further information and prices — or use Reader's Service blank on page 208

Product Literature

• **"Allegheny Metal in Hospitals"** is the title of a new 36 page booklet published by Allegheny Ludlum Steel Corp., Oliver Bldg., Pittsburgh 22, Pa. Starting out with the heading, "Health Protector Number One—The Modern Hospital," the booklet discusses hospitals of today, their evolution and equipment, with particular emphasis on the part played by stainless steel in every department. The booklet is most attractively laid out and printed and contains a wealth of illustration including charts and actual photographs. The material it contains is of definite interest and should be illuminating to the hospital administrator and to all personnel. **(Key No. 911)**

• A folder designed especially to show the comprehensive **service available to hospitals, sanitariums, clinics and related institutions** has been brought out by Frigidaire Division, General Motors Corp., Dayton 1, Ohio. The new folder gives factual information on the complete coverage offered by Frigidaire in refrigeration of all types, air conditioning, water and air coolers, compressors, electric dehumidification and other electrically operated units. **(Key No. 912)**

• Marinite, the Johns-Manville sheet material composed of asbestos fibers, silica and an inorganic binder, is discussed in a folder, **"Build and Insulate with One Material,"** recently released by Johns-Manville, 22 E. 40th St., New York 16. The four-page illustrated folder gives information on the structural use of Marinite for insulation and fireproofing as well as for other construction purposes. **(Key No. 913)**

• **Monarch Dietetic Fruits and Vegetables** are discussed in a folder recently released by Reid Murdoch, P. O. Box 5009, Chicago 80. Included are data on the composition and nutritive value of Monarch products in chart form as well as analytical data and general information on Monarch dietetic foods. **(Key No. 914)**

• Catalog information on **Victor Medical Gas Therapy Equipment** is presented in a new 12 page bulletin recently issued by Victor Equipment Co., 844 Folsom St., San Francisco 7, Calif. Included is descriptive information on Victor regulators, humidifiers, wall outlets, wall valves, manifolds and signals. All items are illustrated. **(Key No. 915)**

• The National Automatic Sprinkler and Fire Control Association, 205 E. 42nd St., New York 17, has published a booklet on **"The Automatic Sprinkler System"** which should be of interest to hospital administrators and those responsible for maintenance. **(Key No. 916)**

• The surgical lighting regulations of the **new Safety Code** have been digested in an article by E. H. Greppin and made available by Wilmot Castle Co., Rochester 7, N. Y. With the article is a folder on the new **Explosion-Proof Safelights** announced by the company. The folder gives technical data and specifications on the new lights together with prices and illustrations of the lights in use. **(Key No. 917)**

• A comprehensive catalog on **"Kardex Visible Record Control"** has recently been published by Remington Rand Inc., 315 Fourth Ave., New York 10. The new 80 page catalog has been completely revised and brought up to date in the matter of all phases of the Kardex Visible Control principle. Included is data on the various combinations of record forms, the variety of colored signal control methods and new computing charts. **(Key No. 918)**

• A new bulletin on **Aluminum Sectional Rolling Scaffolds** has been released by the Patent Scaffolding Co., Inc., 38-21 12th St., Long Island City 1, N. Y. The bulletin gives specifications and descriptive information on the scaffolding and shows illustrations of scaffolds in actual use. **(Key No. 919)**

• A new folder on the **"Kellogg Select-O-Phone"** has recently been made available by the Select-O-Phone Division, Kellogg Switchboard & Supply Co., 6650 S. Cicero Ave., Chicago 38. Descriptive information on the operation of this system, together with illustrations of its component parts and typical uses of the system, are included. **(Key No. 920)**

• **"A Quarter Century in the Service of Science"** is the title of a booklet published by The Williams & Wilkins Co., Mt. Royal and Guilford Aves., Baltimore 2, Md. The booklet gives the history of this publishing firm with information on its various departments and personnel. **(Key No. 921)**

• **"The Fundamentals of Fire Extinguishment"** is the title of an illustrated four page booklet on fire and how to extinguish it. Published by the Ansul Chemical Co., Marinette, Wis., the booklet gives basic information that should be helpful for distribution to fire protection personnel. **(Key No. 922)**

• A new catalog of **"Industrial and Institutional Floor Treatments and Maintenance Products"** has recently been issued by Empire Chemical Products Co., 10 Longworth St., Newark 2, N. J. Descriptive information is presented on the complete line of maintenance equipment and supplies offered by the company and the spiral bound catalog is easy to use. **(Key No. 923)**

• Features of the **Ideal Underbed Oxygen Tent** are discussed in a new 4 page folder released by Thomas A. Edison, Incorporated, Medical Gas Div., Stuyvesant Falls, N. Y. The amount of floor space saved by use of the new tent, because refrigerating components are rolled out of the way under the bed, is discussed as are the new jeweled on-off oxygen flow indicator, no-draft circulation, independent blower control, temperature control system and easily operated patient's call box. **(Key No. 924)**

• Two booklets for hospital distribution to patients to provide information on hospitals are offered without charge by The Birtcher Corporation, 5087 Huntington Drive, Los Angeles 32, Calif. The revised booklet, **"Is a Hospital a Business . . .?"** is written in a friendly style with amusing sketches throughout. It can be adapted for use by any hospital. The second booklet is a **"Check List of Potential Gifts"** which lists things the hospital can use under cost groupings. **(Key No. 925)**

• **"Filters and Lens Attachments"** is the title of a new Kodak technical catalog which presents comprehensive data on the applications, available forms and prices of Kodak Wratten Filters and other Kodak optical attachments. Issued by the Eastman Kodak Co., Rochester 4, N. Y., the booklet sells for 50 cents a copy. **(Key No. 926)**

• The various uses of **Pneumatic Tube systems** are illustrated and described in **Bulletin No. 11** recently published by Standard Conveyor Co., North St. Paul 9, Minn. The bulletin describes four modern installations and discusses savings effected by them. **(Key No. 927)**

• **"Antibiotics"** is the name of a new medical journal announced by the Washington Institute of Medicine, 1523 L St. N. W., Washington, D. C., for publication beginning with the January, 1951 issue. Dr. Henry Welch, who directs the antibiotics division of the Federal Food and Drug Administration, will be editor, assisted by nearly 50 internationally known authorities. The new journal will be published to meet the need for a special scientific publication in the field of antibiotics. **(Key No. 928)**

How **"Nu-Grain for Modernizing Furniture"** can help to brighten up old furniture is discussed in a folder recently released by Nu-Grain Corporation of America, 1805 S. Michigan Ave., Chicago 16. **(Key No. 929)**

• A complete descriptive catalog of **"Hoeber-Harper Medical Books and Journals"** has recently been published by Paul B. Hoeber, Inc., 49 E. 33rd St., New York 16. **(Key No. 930)**

Address manufacturers for further information and prices—or use Reader's Service blank on page 208

• The various uses to which **PC Foamglas insulation** can be put are discussed in a new 36 page booklet recently released by Pittsburgh Corning Corp., 307 Fourth Ave., Pittsburgh 22, Pa. Included in the booklet is new information concerning the installation of Foamglas in floors, as a wall lining and for ceiling insulation, together with technical data and facts about PC accessory materials. **(Key No. 931)**

• Detailed information on the **Casady Hypodermic Needle Cleaner** is offered in a folder on that subject issued by The John Bunn Corp., 163 Ashland Ave., Buffalo 22, N. Y. Descriptive data on the machine and its operation and the time saved by its use are included. **(Key No. 932)**

• **"Calgon Controls Corrosion"** is the title of a new folder offered by Calgon, Inc., Hagan Bldg., Pittsburgh 30, Pa. Information in the folder describes and illustrates the "threshold treatment" for protecting water systems against general corrosive attack and for controlling corrosion of hot water systems. **(Key No. 933)**

• The fresh bright colors in which Vitachrome, the new resilient flooring, is available are shown in **"The New Vitachrome"** folder released by The Tile-Tex Division, The Flintkote Co., Chicago Heights, Ill. Brief specifications of the new grease-resistant, easy to clean flooring are given, together with suggested floor designs in full color. **(Key No. 934)**

• The technics to be followed while giving an intravenous infusion are shown in a new medical motion picture, **"I. V. Stat,"** recently released by Cutter Laboratories, Berkeley 10, Calif. The motion picture is in full color and sound with a running time of 20 minutes. It was filmed with the cooperation of the School of Nursing, Highland Alameda County Hospital, Oakland, Calif. The second part of the film explains how hospital solutions are produced. **(Key No. 935)**

• Lamson Pneumatic Dispatch Tubes, Vertical Conveyors and Trayveyors and Make-up Conveyors are illustrated and described in a 4 page **Hospital Bulletin** recently released by Lamson Corporation, Syracuse 1, N. Y. Headed by the statement "For Greater Speed, Efficiency and Economy Modern Hospitals Use These Essential Services," the bulletin discusses the various uses to which these systems can be put in the hospital and illustrates typical Lamson installations. **(Key No. 936)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it. If you read the hospital copy or the administrator's copy of The MODERN HOSPITAL or for any other reason do not wish to clip the magazine itself, upon request we shall be glad to send you regularly a reprint of this department containing the coupon.

Bessie Covert
Editor, "What's New for Hospitals"

- ☐ 860 Developing Tank
- ☐ 861 Improved Anacap Silk
- ☐ 862 Static-Free Microtome
- ☐ 863 Agimatic Liquid Dispenser
- ☐ 864 Rust Inhibiting Germicide
- ☐ 865 Combination Pad
- ☐ 866 Blade Sterilizing Jar
- ☐ 867 Toilet Partitions
- ☐ 868 Dietetic Tuna
- ☐ 869 Curtain Rollers
- ☐ 870 Compressor
- ☐ 871 Post Operative Stretcher
- ☐ 872 Portable Typewriter
- ☐ 873 Pot and Pan Washer
- ☐ 874 Free-Flow Salt Shakers
- ☐ 875 Pre-Flush Dishwasher
- ☐ 876 Ethicon Surgiset
- ☐ 877 Vegetable Peeler
- ☐ 878 Portable Darkroom
- ☐ 879 Unit Heaters
- ☐ 880 Utility Cart
- ☐ 881 Salamander Broiler
- ☐ 882 Steam Trap
- ☐ 883 Dishwashing Machine
- ☐ 884 Dual-Hite Gatch Bed
- ☐ 885 Adhesive Remover
- ☐ 886 Floor Maintenance
- ☐ 887 Adjusto Crutch
- ☐ 888 Baker's Oven
- ☐ 889 Insecticide
- ☐ 890 Copying Unit
- ☐ 891 Floor Seals
- ☐ 892 Patient Chair
- ☐ 893 Plastic Cleanser
- ☐ 894 Conductive Sole Shoe
- ☐ 895 Steel Doors and Door Hardware
- ☐ 896 Stencil Duplicator
- ☐ 897 Butter Pats
- ☐ 898 Antiseptic Liquid Soap
- ☐ 899 Freeze-Drying Unit
- ☐ 900 Locked Floor Drain
- ☐ 901 Automatic Cutoff
- ☐ 902 NPH Iletin
- ☐ 903 Dayalets
- ☐ 904 Carboxy Methyl Cellulose
- ☐ 905 Dram-Cillin
- ☐ 906 Prulose Complex
- ☐ 907 NPH Insulin Squibb
- ☐ 908 Biosulfa
- ☐ 909 Neovacagen
- ☐ 910 Vasoxyl
- ☐ 911 "Allegheny Metal in Hospitals"
- ☐ 912 Hospital Equipment
- ☐ 913 Marinite
- ☐ 914 Dietetic Fruits and Vegetables
- ☐ 915 Medical Gas Therapy Equipment
- ☐ 916 "Automatic Sprinkler System"
- ☐ 917 Safety Code on Safelights
- ☐ 918 "Kardex Record Control"
- ☐ 919 Aluminum Scaffolds
- ☐ 920 "Kellogg Select-O-Phone"
- ☐ 921 "Quarter Century of Service"
- ☐ 922 "Fundamentals of Fire Extinguishment"
- ☐ 923 "Floor Maintenance Products"
- ☐ 924 Ideal Underbed Oxygen Tent Folder
- ☐ 925 "Is a Hospital a Business"
- ☐ 926 "Filters & Lens Attachments"
- ☐ 927 Bulletin No. 11
- ☐ 928 "Antibiotics" Journal
- ☐ 929 "Modernizing Furniture"
- ☐ 930 Hoeber-Harper Catalog
- ☐ 931 PC Foamglas Insulation
- ☐ 932 Needle Cleaner Folder
- ☐ 933 "Calgon Controls Corrosion"
- ☐ 934 "The New Vitachrome"
- ☐ 935 "I.V. Stat"
- ☐ 936 Hospital Bulletin
- ☐ 937 "Snow Melting"
- ☐ 938 "Food and Nutrition Manual"

I should also like to have information on the following products

NAME _____ TITLE _____

HOSPITAL _____

STREET _____

CITY _____ ZONE _____ STATE _____

MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

Book Announcements

Adlam, "Snow Melting," Design, Installation and Control of Systems for Melting Snow by Means of Hot Water Coils, 224 pp., $4.50. **The Industrial Press, Dept. MH, 148 Lafayette St., New York 13. (Key No. 937)**

"Food and Nutrition Manual," for children's institutions, summer camps, day nurseries and homes for the aged, $2, published by **The Welfare Federation of Cleveland, Dept. MH, 1001 Huron Rd., Cleveland 15, Ohio. (Key No. 938)**

Suppliers' News

Columbus-Dixon, Inc., is the new name of the company formerly known as Columbus Combined Floor Polishers & Cleaners, Inc., distributors of the "Columbus" Suction Polisher and Cleaner for complete floor maintenance. The company continues at the same address, **333 E. 23rd St., New York 10.**

United States Air Conditioning Corp., Como Ave., S. E., Minneapolis 14, Minn., manufacturer of air conditioning equipment, announces the opening of a new sales office at **516 Maverick Bldg., San Antonio, Texas.** The new office will be headed by **Robert Dawson.**

Printed in U.S.A.

PREFERRED for CREAM SERVICE

Hall creamers are pure white inside and can be kept that way permanently with a minimum of cleaning and sterilizing. Made of heavy, fireproof china by an exclusive process, they are crazeproof, absorption-proof, and stainproof. Reasonable first cost and extreme durability make them the most economical creamers you can buy.

Write on company letterhead for Catalog 48 which lists almost 1,000 different Hall China items and contains a color chart of the 26 beautiful underglaze colors that are available.

THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

Hall Creamers are made in sizes ranging from individual to banquet service. Sugars are also available.

Shaping Hall China Cream Bottle

HALL
Secret Process
FIREPROOF CHINA

Gumpert Products Are Star Performers in Hospitals Everywhere

For quality that's always a winner, you can rely on Gumpert food specialties. Back of each of our hundreds of items is more than a half century of food pioneering. Finer ingredients and better know-how make Gumpert foods truly outstanding—and you get thrift as well as quality, while saving time and effort, too. See the Gumpert man when he calls.

GUMPERT

OUTSTANDING QUALITY FOR HOSPITALS

300 Products to Aid Restaurant Operations

- Gelatine Desserts
- Cream Desserts
- Fruit Drinks—(Liquid and Dehydrated
- Extracts and Colors
- Spaghetti Sauce
- Soups—(Liquid and Dehydrated)
- Cake Mixes
- Hot Chocolate Powder
- Soda Fountain Toppings
- Complete Line of Bakery Specialties

S. GUMPERT CO., INC. OZONE PARK 16, N. Y.

CHICAGO SAN FRANCISCO